Filing at a Glance

Company:	Community Health Alliance Mutual Insurance Company
Product Name:	CHA Individual
State:	Tennessee
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005A Individual - Preferred Provider (PPO)
Filing Type:	Form/Rate
Date Submitted:	06/13/2013
SERFF Tr Num:	CHAM-129074749
SERFF Status:	Assigned
State Tr Num:	H-130572
State Status:	Assigned - Pending Review
Co Tr Num:	
Implementation Date Requested:	01/01/2014
Author(s):	Cannon Witt
Reviewer(s):	Vicky Stotzer (primary), Brian Hoffmeister, Melissa Merritt
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

I IHM P

PTN_100_14

individual health insurance exchange forms and rates

State: *Tennessee* ***Filing Company:*** *Community Health Alliance Mutual Insurance Company*

TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*

Product Name: *CHA Individual*

Project Name/Number: */*

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Cannon Witt

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 05/01/2013

Domicile Status Comments:

Market Type: Individual

Individual Market Type: Individual

Filing Status Changed: 06/14/2013

State Status Changed: 06/14/2013

Created By: Cannon Witt

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

CHA 2014 Individual Rates and Forms

Company and Contact

Filing Contact Information

Jim Mitchell, Director of Compliance
445 S Gay Street
Knoxville, TN 37902

jmitchell@chatn.org
865-314-0384 [Phone]

Filing Company Information

Community Health Alliance Mutual Insurance Company
445 S Gay Street
Knoxville, TN 37902
(888) 415-3332 ext. [Phone]

CoCode:
Group Code:
Group Name:
FEIN Number: 45-3127905

State of Domicile: Tennessee
Company Type:
State ID Number:

Filing Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

SERFF Tracking #:	*CHAM-129074749*	***State Tracking #:***	*H-130572*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CHA Individual*		
Project Name/Number:	*/*		

Correspondence Summary

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Individual	Cannon Witt	06/14/2013	06/14/2013
Rate	CHA Individual On Exchange Rates	Cannon Witt	06/14/2013	06/14/2013
Supporting Document	Modified Plan and Benefits	Cannon Witt	06/14/2013	06/14/2013

SERFF Tracking #:	*CHAM-129074749*	***State Tracking #:***	*H-130572*	***Company Tracking #:***

State:	*Tennessee*	***Filing Company:***	*Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CHA Individual*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 06/14/2013

Comments:

Change for split between on/off exchange.

Changed Items:

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Individual	PTN_100_14	SCH	Initial		0.000	Individual On Exchange Schedules.pdf	Date Submitted: 06/14/2013 By:
Previous Version								
1	*Individual*		*SCH*	*Initial*		*0.000*	*Individual Schedules.pdf*	*Date Submitted: 06/13/2013 By: Cannon Witt*

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	CHA Individual On Exchange Rates	PTN_100_14	New		CHA Individual_OnExchange_SERFF Format.xls,	06/14/2013 By:
Previous Version						
1	*CHA Individual Rates*	*PTN_100_14*	*New*		*CHA Individual_SERFF Format.xls,*	*06/13/2013 By: Cannon Witt*

SERFF Tracking #:	*CHAM-129074749*	***State Tracking #:***	*H-130572*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CHA Individual*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Modified Plan and Benefits
Comments:	Removed Modified as it only applies to off exchange.
Attachment(s):	
Previous Version	
Satisfied - Item:	*Modified Plan and Benefits*
Comments:	
Attachment(s):	*ModifiedPlanandBenefitChart_Individual_OffExchange.xlsx*

SERFF Tracking #:	*CHAM-129074749*	***State Tracking #:***	*H-130572*	***Company Tracking #:***

State:	*Tennessee*	***Filing Company:***	*Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CHA Individual*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Individual EOC	PTN_100_14	POL	Initial		42.500	Individual EOC.pdf
2		Individual	PTN_100_14	SCH	Initial		0.000	Individual On Exchange Schedules.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

INDIVIDUAL HEALTH BENEFIT POLICY

COMMUNITY HEALTH ALLIANCE MUTUAL INSURANCE COMPANY

PLEASE READ THIS EVIDENCE OF COVERAGE CAREFULLY. KEEP IT IN A SAFE PLACE. IT EXPLAINS YOUR COVERAGE FROM COMMUNITY HEALTH ALLIANCE. IF YOU HAVE ANY QUESTIONS, PLEASE CALL OR WRITE CUSTOMER SERVICE, OR YOU MAY VISIT OUR WEBSITE AT: www.chatn.org

This Policy contains a 10 day "Free Look" period. This means that the You are permitted to return this Policy to Community Health Alliance within 10 days of its delivery to You, and to have any Premium paid immediatedly refunded to You if You are dissatisfied with the Policy for any reason.

COMMUNITY HEALTH ALLIANCE
MUTUAL INSURANCE COMPANY
445 S. GAY ST. SUITE 101
KNOXVILLE, TN 37421
865-862-4164

POLICY

This Policy explains Your coverage. It replaces any Policy that You previously received from Community Health Alliance (CHA).

Please read this Policy carefully. It describes your rights and duties as a Subscriber. It is important to read the entire Policy. Certain services are not covered. Other covered services are limited unless CHA pre-approves them. CHA will not pay for any service not specifically listed as a Covered Service, even if a health care provider recommends or orders that Non-Covered Service.

CHA will make any benefit or eligibility determinations. It will also construe the terms of your coverage under the Policy. CHA will be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations.

Please contact Customer Service at the number listed on your Subscriber ID card if You have any questions regarding this Policy or any other matters related to your coverage from CHA.

The benefits described in this Policy are referred to as "the Health Policy," or simply "the Policy."

POLICY TERMS

This Policy describes the Policy as of January 1, 2014.

RIGHT TO AMEND OR TERMINATE

The Insurer has the right, at any time, to amend or terminate the Policy, as described on page 54 in the *General Information* section of this Policy.

RIGHT TO INTERPRET

CHA has full discretion to make factual determinations and to interpret the Policy.

MODIFICATIONS NOT PERMITTED

This Policy cannot be modified by oral statements or by unofficial communications, such as e-mail or mailings. CHA can only modify this Policy with an official amendment.

EXAMINATION OF POLICY

You have 10 days from the receipt of this Policy to examine its provisions, and for any reason, return the policy to CHA. Any Premium You have paid will be immediately returned upon surrender of this Policy to CHA.

TABLE OF CONTENTS

ELIGIBILITY AND ENROLLMENT

WHEN COVERAGE BEGINS AND ENDS

ELIGIBILITY AND ENROLLMENT

INDIVIDUAL ELIGIBILITY

You are eligible to participate in the Policy if …
• You are a resident of the state of Tennessee; and • You have submitted a completed and signed application for coverage and have been accepted in writing by CHA.

DEPENDENT ELIGIBILITY

If You are eligible for coverage, You may also cover your Eligible Dependents under the Policy. Social Security numbers are required for enrollment of all dependents. Eligible Dependents are:

- Your spouse. Your spouse is your current husband or wife as recognized by Tennessee law.
- Your Domestic Partner. Tax consequences may exist for coverage of Domestic Partners.
- Your children 26 and younger.

  Your children are:

  - Your natural or lawfully adopted children (including children placed for adoption), stepchildren and persons for whom You are the legal guardian;
  - Children for whom You are responsible for coverage under the terms of a court decree a Qualified Medical Child Support Order (a QMCSO).
- Your unmarried children over age 26 who are unable to support themselves because of a permanent mental or physical handicap and are dependent on You for support and maintenance. These children must be considered dependents for income tax purposes. This Policy must have covered these children prior to reaching age 26. You must provide CHA with proof of the child's disability within 31 days after his or her coverage would otherwise end. Thereafter, You must provide proof of the disability once a year after the two year period following the child reaching age 26.

Individuals who permanently reside outside the United States are not eligible for coverage under this Policy.

CHA's determination of eligibility under the terms of the Policy shall be conclusive.

CHA reserves the right to require proof of eligibility.

PREMIUMS

You will be required to pay for the Premium for coverage under this Policy. If You do not pay all of the Premium, the rest may be paid, if applicable, by Your Advanced Premium Tax Credit (APTC).

If You receive an APTC and have not paid Your Premium when due, You are entitled to a grace period of 3 months in a row to pay Your Premium. This grace period will apply only if You have paid at least one month's full Premium during the Policy Year. Coverage will continue during the first month of the grace period, but CHA will suspend payment of claims for any Covered Services during the second and third months of the grace period if no Premium payments are made. If the grace period of 3 months ends without You paying all outstanding Premiums, coverage will end as set forth in the "When Your Coverage Ends" section below.

If You do not receive an APTC, You are entitled to a grace period of 31 days for payment of Your Premium, except for the first Premium due. Coverage will continue during the grace period, unless You provide CHA with written notice of prospective cancellation in accordance with the terms of the Policy. You may be liable for a prorated Premium for coverage provided during the grace period.

You will be provided with written notice at least 31 days prior to the date any increase in Premium rate would become effective.

IF BOTH YOU AND YOUR SPOUSE HAVE COVERAGE UNDER THE POLICY

Married couples may enroll in whatever combination of single or married coverage that meets their needs. However, under the same Policy, no individual may be covered as both an individual and a dependent, and dependents cannot be covered by more than one individual.

ANNUAL ENROLLMENT

Your election to have coverage under this Policy will continue each year unchanged, unless You decide to terminate coverage and stop paying Premiums, or elect another policy option during Open Enrollment.

Changes made during Open Enrollment are effective January 1st immediately following Annual Enrollment.

NON-DISCRIMINATION

Your or your dependents' eligibility will not be based on any of the following health status related factors:

- Health status;
- Medical condition, including both physical and mental illnesses;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability, including conditions arising out of acts of domestic violence; or
- Disability.

You will not be required to pay a Premium which is greater than that for a similar individual with coverage under the same or similar Policy because of Your health status related factor or that of Your Dependent, unless allowed by law.

WHEN COVERAGE BEGINS AND ENDS

WHEN YOU AND YOUR DEPENDENTS' COVERAGE BEGINS

You and your Dependents' coverage begins on the earliest of the following dates:

- The date You become eligible, if You apply on or before that date or within 31 days after that date;
- The first day of the month following CHA's receipt of your application and Premium.

WHEN YOU AND YOUR DEPENDENTS' COVERAGE ENDS

You and your Dependents' coverage under the Policy will end:

- When Premiums are not paid by the due date required and any grace period described in this Policy has ended;
- When You are no longer eligible for coverage under this Policy;
- If You commit any fraud or deception or intentional misrepresentation of material fact in connection with this Policy;
- When the Policy no longer offers coverage of this type to all individuals in your class, Tennessee law requires that CHA:
  - Provides You with written notice of the discontinuation before the 90th day before the date of the discontinuation of coverage;
  - Offer You, on a guaranteed basis, the option to purchase any other individual health plan that CHA offers at the time; and
  - Act without regard to any health status related Your or Your Eligible Dependents may have.
- If CHA stops offering any individual policies in Tennessee, CHA will notify You of the end of coverage at least 180 days prior to cancellation; or
- When You no longer live in the service area.

PAYMENT FOR SERVICES RECEIVED AFTER END OF COVERAGE

If You receive Covered Services after the end of your coverage, CHA may recover the amount paid for such services from You, plus any costs of recovering such charges, including attorney's fees.

EXTENDED BENEFITS

If You are hospitalized on the date the Policy ends, benefits for Hospital Services will be provided: for 60 days; until You are covered under another policy; or until You are discharged, whichever occurs first. This will not apply to Your newborn child if an application for that child has not been submitted within 31 days following the child's birth.

THE
HEALTH POLICY

HIGHLIGHTS OF THE HEALTH POLICY

This is a description of the Policy, as of January 1, 2014.

The Policy offers health services through a network of Providers that have agreed to charge Subscribers negotiated rates for health care. The specific services that are covered under the Policy, and the limits that apply, are described in this Policy. You are required to use an In-Network Provider for Covered Services, except in the case of an Emergency.

THE HEALTH POLICY

- lets **You** choose your own In-Network Provider. You are required to use an In-Network Provider for all Covered Services except in the case of Emergency;
- covers qualifying preventive care services at 100% at a Network Provider (see the *Schedule of Benefits* for each Policy option for specifics); and
- offers the added benefit of health resources to help You make informed decisions about Your family's health care purchases. For more information, visit www.chatn.org.
- contracts with Providers who agree not to Balance Bill You for the difference between the amount they charge and the amount CHA pays, except for any required Coinsurance, Copayments or Deductibles.

CHANGING COSTS

CHA may modify this Policy, including provisions, benefits and coverage, so long as such modification is consistent with state or federal law and effective on a uniform basis among all individuals with coverage under the same policy. CHA will send written notice and the change will become effective on the date shown in the notice or on the next scheduled Premium due date thereafter. Payment of Premiums will indicate acceptance of the change.

Please read this Policy thoroughly to learn how your Health Insurance works.

If you have questions, please call Customer Service at the number listed on Your ID card.

YOUR COSTS UNDER THE HEALTH POLICY

DEDUCTIBLE

You may have to satisfy an up-front Policy Year Deductible, as stated in the *Schedule of Benefits*, before CHA begins to pay. The Deductible does not apply to certain preventive care services received from a Network Provider.

If You cover Yourself and Dependent(s), and one or more family members together incur Covered Expenses to meet the family Deductible, no further Deductible will be required from any family member for the remainder of the Policy Year.

Note: The Deductible is sometimes referred to as *Subscriber responsibility*.

COINSURANCE

Once You meet the Policy Year Deductible, CHA pays the percentages shown in the *Schedule of Benefits* Covered Services. You pay any remaining percentage, which is Your Coinsurance.

COPAYMENTS

A Copayment is a fixed amount You pay for a Covered Service, usually when You receive the service. The amount can vary by the type of Covered Service.

MAXIMUM OUT OF POCKET

The Maximum Out of Pocket (MOOP) is the most You will pay before CHA begins to pay 100% of the cost of Covered Services for the remainder of the Policy Year for a Network Provider, subject to the Maximum Individual Limit or other exclusions.

Expenses paid to satisfy the Policy Year Deductible, Copayments, or Coinsurance payments will be used to meet the MOOP. Please see the Schedule of Benefits(Exhibit A) for details about your Copayment and Coinsurance amounts. If You cover one or more family members, expenses for all of your family members combined will apply to Your Policy Year family MOOP.

PREVENTIVE CARE SERVICES

Qualifying Preventive Care Services are covered 100% if received from a Network Provider**.** Qualifying Preventive Care Services and benefits are covered with no Deductible, Co-pay, or Coinsurance.

For a complete list of qualifying Preventive Care Services, see the section entitled, *Preventive Care Services – Schedule of Benefits* in Exhibit A. You may choose other preventive care services or to receive Preventive Care Services from an Out-of-Network Provider; however, any such services will not be covered or may be considered as any other claim.

HEALTH RESOURCES

IMPORTANT INFORMATION ABOUT THE MATERIAL FOUND IN THIS SECTION

Information obtained through these services is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help You make better health care decisions.

CHA is not responsible for any results from Your decision to use the information, including, but not limited to, Your choosing to seek or not to seek professional medical care, or Your choosing or not choosing specific treatment.

PATIENT SUPPORT

The goal of the Care Management Program is to support Your health care needs and educate You about Your benefits and available resources.

Nurses provide different services to help Subscribers receive appropriate medical care. The Program is subject to change without notice. Services may include:

- **Admission counseling** – For upcoming inpatient hospital admissions, a health coach may call You to answer questions and to make sure You have information to support Your recovery.
- **Inpatient care advocacy** – If You are hospitalized, a health coach may work with Your treatment team to make sure You are getting the care You need and that your treatment plan is being carried out effectively.
- **Transition of Care** – After leaving the hospital, You may receive a phone call from a nurse if You have certain chronic or complex conditions. This program serves as a bridge for improved coordination of care between facility to facility or home transfers. The nurse will also confirm your medications, any required equipment, or that follow-up services are in place.

If You do not receive a call from a nurse but feel You could benefit from any of these programs, please call Customer Service at the number listed on your ID card.

PREAUTHORIZATION

Some services require prior authorization from CHA. Your Provider must get this prior authorization. If Your Provider does not get prior authorization, Your claim for benefits may be reduced or denied. The services and devices for which Your Provider is required to obtain prior authorization include but are not limited to:

- Hospital Observation
- All non-emergent inpatient admissions to any facility including:
    - Inpatient rehabilitation
    - Skilled nursing (up to 30 days if medically necessary)
    - Mental health
    - Substance abuse
- The purchase of any durable medical equipment over $500
- All rented durable medical equipment.
- Home care services including infusion therapy
- Orthopedic footwear, shoe modifications and additions that costs more than $300
- Some surgical/interventional services performed in an outpatient hospital or ambulatory surgery setting including but not limited to:
    - Chemotherapy
    - Cosmetic procedures
    - Dental, jaw and face procedures
    - Dental/oral surgery requiring general anesthesia
    - Oral pharynx procedures
    - Nuclear cardiology tests
    - Abortion
    - Hysterectomy
    - Genetic testing
    - Hyperbaric oxygen therapy
    - Infusion Centers
    - OB ultrasounds exceeding three per pregnancy
    - Pain management programs including epidurals, nerve blocks, facet injections, pain management pumps, dorsal column stimulators
- Chiropractic services in excess of 6 visits annually
- Physical therapy after the tenth visit
- Occupational therapy after the tenth visit
- Speech therapy after the tenth visit
- Cardiac and Pulmonary rehabilitative services
- Developmental Evaluation and Treatment Services
- Respiratory therapy services except for initial evaluation

- MRI, MRA, MRS, MRT when not performed in the emergency room or as part of an approved inpatient confinement
- PET or SPEC scans when not performed in the emergency room or as part of an approved inpatient confinement
- CT, CTA scans when not performed in the emergency room or as part of an approved inpatient confinement
- Transplant services
- Hospice
- Implantable devices including cochlear implants
- Sleep studies, sleep therapies and supplies
- Any Out of Network requests

For a complete list of services requiring prior authorization, please visit www.chatn.org.

RESOURCES TO HELP YOU STAY HEALTHY

CHA believes in giving You the tools You need to be an educated health care consumer. CHA has several educational and support services which can help You to:

- take care of Yourself and Your family members
- manage a chronic health condition
- navigate the health care system

HEALTH RESOURCES WEBSITE

www.chatn.org provides information anywhere and anytime You have access to the internet. The Subscriber website opens the door to a wealth of health information and easy to use self-service tools.

REGISTERING ON WEBSITE

If You have not already registered go to www.chatn.org. Have Your ID card handy. The enrollment process is quick and easy.

If You do not know Your logon ID, contact Customer Service. The phone number is located on Your ID card.

HEALTH INFORMATION

You can:

- Search for Network Providers through the online Provider directory
- Research a health condition and treatments to get ready for a visit with Your Physician
- Access wellness topics from Health Coaches
- Complete a health risk assessment to learn about areas of Your health that can be improved so You can live a longer and more productive life.
- Use the treatment cost estimator to estimate the cost of a procedure.

SELF-SERVICE TOOLS

Visit www.chatn.org to:

- make real-time inquiries into the status and history of Your claims
- view eligibility and Policy benefit information, including deductibles
- view and print all of Your Explanation of Benefits (EOBs)
- order a new or replacement ID card

If You do not have access to a computer, You can get the same information by contacting Customer Service at the number on Your ID card.

DISEASE MANAGEMENT PROGRAM

Disease Management (DM) is a program to support Subscribers. In DM, Subscribers will work with health coaches to set goals, discuss treatment options and improve their overall health. Through health coaching, You will also get guidance on maintaining a healthy lifestyle and how to follow treatment and medication plans. DM is available at no cost to all Subscribers. There are disease management programs for:

- Coronary Artery Disease
- Diabetes
- Depression
- Attention Deficit with Hyperactivity Disorder (ADHD)

LIFESTYLE MANAGEMENT

Lifestyle Management is health coaching designed to help Subscribers reach their individual health goals. Lifestyle changes are hard and whether You are making a small change or a large one, coaching can make a huge difference in helping You reach Your health goals. Lifestyle Management programs may include:

- Nutrition
- Exercise
- Blood Pressure
- Cholesterol
- Tobacco Cessation
- Weight Management
- Stress Management
- Back Care

WHAT'S COVERED UNDER THE HEALTH POLICY

The Health Plan covers many Medically Necessary services and supplies, subject to any limits or exclusions set forth in the Summary of Benefits. However, the Plan only covers care provided by healthcare professionals or facilities licensed, certified or otherwise qualified under state law to provide healthcare services.

PREVENTIVE CARE SERVICES

The following is a list of services required by the Patient Protection and Affordable Care Act and included in the United States Preventive Services Task Force (USPSTF) A and B Recommendations, as amended from time to time. Such services are payable at 100% at a Network Provider with no need to satisfy the Plan Year Deductible or pay any coinsurance.

If You do not receive these services from a Network Provider, Deductible and Coinsurance will apply or the Claim may be denied.

WELL-CHILD CARE

Well-child care includes:

- Alcohol and Drug Use – annual assessments for adolescents;
- Autism – screening for children at 18 and 24 months;
- Behavioral – annual assessments for children of all ages;
- Blood Pressure – annual screening for children age 0-18;
- Cervical Dysplasia – annual screening for sexually active females;
- Congenital Hypothyroidism – screening for newborns;
- Developmental – screening for children under age 3 and surveillance throughout childhood;
- Dyslipidemia – annual screening for children at higher risk of lipid disorders;
- Fluoride Chemoprevention – fluoride supplements prescribed by a primary care physician for preschool children older than 6 months whose primary water source is deficient in fluoride;
- Gonorrhea – prophylactic ocular topical medication for all newborns;
- Hearing – screening for hearing loss in all newborns;
- Hematocrit or Hemoglobin – annual screening for children;
- Hemoglobinopathies – screening for sickle cell disease in newborns;
- Hypothyroidism – screening for congenital hypothyroidism in newborns;
- Immunization – vaccines for children from birth to age 18, recommended ages, frequency and populations will vary with each vaccine;
- Iron – supplements for asymptomatic children age 6 to 12 months who are at increased risk for iron deficiency anemia;
- Lead – annual screening for children at risk of exposure;
- Obesity – annual screening and counseling for children age 6 and older;
- Phenylketonuria (PKU) – screening for PKU in newborns;
- Skin Cancer – behavioral counseling for children, adolescents and young adults ages 10-24 who have fair skin about minimizing exposure to ultraviolet radiation to reduce risk for skin cancer;
- Tuberculin – testing for children at higher risk of tuberculosis;
- Vision – screening for all children at least once between the ages 3-5 to detect the presence of amblyopia or its risk factors.

WELL-ADULT CARE

Well-adult care includes:

- Abdominal Aortic Aneurysms – one-time screening for men age 65-75 who have ever smoked;
- Alcohol Misuses – annual screening and counseling in primary care settings;
- Aspirin – use to prevent myocardial infarctions in men age 45-79 and women age 55-79;
- Blood pressure – annual screening for all adults over the age of 18;
- Cholesterol – annual screening for men age 35 and above, for men age 20-35 if they are at increased risk for coronary heart disease, for women age 45 and above, for women age 20-45 if they are at increased risk for coronary artery disease;
- Colorectal cancer – annual screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy for adults age 50-75;
- Depression – annual screening for adolescents age 12-18 for major depressive disorder and adults for depression;
- Type 2 Diabetes – annual screening for adults with sustained high blood pressure;

- Diet – annual counseling for adults at higher risk for diet-related chronic disease;
- Falls prevention – exercise or physical therapy to prevent falls and vitamin D supplementation in community-dwelling adults age 65 and older who are at increased risk for falls;
- Human Immunodeficiency Virus (HIV) – annual screening for all adolescents and adults at increased risk for HIV infection;
- Immunizations – Vaccines for adults, recommended ages, frequency and populations will vary with each vaccine;
- Obesity – screening for obesity with an offer or referral to intensive, multicomponent behavioral interventions for patients with a body mass index of 30 kg/m^2 or higher;
- Sexually Transmitted Infection (STI) – annual prevention counseling for sexually active adolescents and adults at increased risk for STIs;
- Tobacco Use – annual screening for all adults and cessation interventions for tobacco users;
- Syphilis – annual screening for all adults at increased risk for syphilis infection.

WELL-WOMAN CARE

Well-woman care includes:

- Anemia – screening in asymptomatic pregnant women;
- Bacteriuria – urinary tract or other infection screening for pregnant women at 12-16 weeks gestation or the first prenatal visit, whichever is later;
- Breast Cancer Susceptibility Gene Testing (BRCA) – counseling and evaluation for BRCA testing for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 and BRCA2 genes;
- Mammography – screenings once as a baseline for women at least 35 but less than 40, once every 2 years for women at least 40 but less than 50, once per year for women at least 50, or in accordance with the most recent published guidelines of the American Cancer Society;
- Chemoprevention – counseling for women at high risk for breast cancer and low risk for adverse effects of chemoprevention;
- Breastfeeding – support and counseling from trained providers during pregnancy and after birth to promote and support breastfeeding and access to breastfeeding supplies for pregnant and nursing women in conjunction with each birth;
- Cervical Cancer – screening in women ages 21-65 with cytology (pap smear) every 3 years or, for women ages 30-65 who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years;
- Chlamydia Infection – annual screening for all sexually active non-pregnant women age 24 and younger, older non-pregnant women at increased risk, pregnant women age 24 and younger, and older pregnant women who are at increased risk;
- Contraception – Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling as prescribed, not including abortifacient drugs;
- Domestic and Interpersonal Violence – annual screening and counseling for all women;
- Folic Acid – supplements for women planning or capable of pregnancy;
- Gestational Diabetes – screening for women 24-28 weeks pregnant and those at high risk of developing gestational diabetes;
- Gonorrhea – annual screening for all women at increased risk for infection;
- Hepatitis B – annual screening for pregnant women at their first prenatal visit;
- Human Immunodeficiency Virus (HIV) – annual screening and counseling for sexually active women;
- Human Papillomavirus (HPV) DNA Test – High-risk HPV DNA testing every three years for women with normal cytology results who are 30 or older;
- Intimate partner violence screening – screening for women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This applies to women who do not have signs or symptoms of abuse;
- Osteoporosis – screening for osteoporosis in women age 65 and older and in younger women whose fracture risk is equal or greater than that of a 65 year old white woman who has no additional risk factors;
- Rh Incompatibility – screening for all pregnant women during their first prenatal visit and follow-up testing for women at higher risk at 24-28 weeks gestation;
- Tobacco Use – annual screening and interventions for all women

and expanded counseling for pregnant tobacco users;

- Syphilis – screening for all pregnant women;
- Well-Woman Visits – annual visits to obtain recommended preventive services.

Please note that any preventive care services not listed above, including l prescriptions, will not be payable at 100%. Instead, they will be subject to Deductible, Coinsurance and Co-Pays, as applicable.

STANDARD SERVICES COVERED UNDER HEALTH COVERAGE

The Plan covers a wide range of medical expenses if they are rendered by an In-Network Provider and are determined to be Medically Necessary or usual to the treatment of Your Illness or Injury. The Plan's medical staff or an independent medical Physician review panel will decide if the treatment is Medically Necessary.

When more than one treatment alternative exists, each is Medically Appropriate and Medically Necessary, and each would meet Your needs, the Plan reserves the right to provide payment for the least expensive Covered Service alternative.

The following is a listing of Covered Expenses payable under the Plan:

AMBULANCE SERVICES

Medically Necessary and Appropriate land or air transportation, services, supplies and medications by a licensed ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to You. Covered services include:

- Medically Necessary and Appropriate land or air transportation to or from the scene of an accident or Emergency.

BEHAVIORAL HEALTH

Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features. Covered services include:

- Inpatient and outpatient services for care and treatment of mental health disorders and substance abuse disorders;
- Treatment of medical conditions underlying, or resulting from, behavioral health disorders.

DENTAL SERVICES

- Medically Necessary and Appropriate services performed by a Doctor of Dental Surgery (DDS), a Doctor of Medical Dentistry (DMD) or any Physician licensed to perform dental related oral surgery except as indicated herein. Covered services include: Dental services and oral surgical care to treat intraoral cancer, or to treat accidental injury to the jaw, sound natural teeth, mouth, or face, due to external trauma. The surgery and services to treat accidental injury must be started within 3 months and completed within 12 months of the accident;
- For dental services not listed above, general anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure are covered, only when one of the 5 conditions listed below is met:
  - Complex oral surgical procedures that have a high probability of complications due to the nature of the surgery;
  - Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications;
  - Mental illness or behavioral condition that precludes dental surgery in the office;
  - Use of general anesthesia and the Subscriber's medical condition requires that such procedure be performed in a Hospital; or
  - Dental treatment or surgery performed on a Subscriber 8 years of age or younger, where such procedure cannot be safely provided in a dental office setting.
- Oral appliances to treat obstructive sleep apnea, if Medically Necessary.
- Routine dental services for children under age 18.

DIABETES TREATMENT

Medically Necessary and Appropriate diagnosis and treatment of diabetes. In order to be covered, such services must be prescribed and certified by a Physician as Medically Necessary. The treatment of diabetes consists of medical equipment, supplies, and outpatient self-management training and education, including nutritional counseling. Covered services include:

- Blood glucose monitors, including monitors designed for the legally blind;
- Test strips for blood glucose monitors;
- Visual reading and urine test strips;
- Insulin;
- Injection aids;
- Syringes;

- Lancets;
- Oral hypoglycemic agents;
- Glucagon emergency kits;
- Injectable incretin mimetics (e.g., Exenatide/Byetta) when used in conjunction with selected Prescription Drugs for the treatment of diabetes;
- Insulin pumps, infusion devices, and appurtenances. Insulin pump replacement is covered only for pumps older than 48 months and if the pump cannot be repaired;
- Podiatric appliances for prevention of complications associated with diabetes.

DIAGNOSTIC SERVICES

Medically Necessary and Appropriate diagnostic radiology services and laboratory tests. Covered services include:

- Imaging services ordered by a Physician, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services. Advanced Radiological Imaging Services include MRIs, CT scans, PET scans, and nuclear cardiac imaging;
- Diagnostic laboratory services ordered by a Physician.

DRUGS

Medically Necessary and Appropriate pharmaceuticals for the treatment of disease or injury. Covered services include:

- Benefits for the treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Physician;
- Pharmaceuticals that are dispensed or intended for use while You are confined in a Hospital, skilled nursing facility or other similar facility.

The Plan includes coverage for Prescription Drugs. You must purchase covered medications from a Network Pharmacy to receive Prescription Drug benefits. If You use a Non-Network Pharmacy, Prescription Drugs will not be covered.

OVER-THE-COUNTER MEDICATIONS

Over-the-counter medications are not a covered benefit, unless they are on the Plan Formulary.

MAINTENANCE DRUGS

If You take a medication on a regular or long-term basis, it may be considered a maintenance medication. You have the option to fill maintenance medications for up to a 90-day supply at either a local retail network pharmacy or at the plan's approved mail order pharmacy. To find out if Your medication is classified as a maintenance drug and eligible for a 90-day supply, please consult the formulary of medications available at www.chatn.org or contact the Customer Service number listed on Your ID card.

SPECIALTY MEDICATIONS

Specific "specialty" medications may only be filled at the plan's approved specialty pharmacy provider to receive benefits. If these "specialty" medications are filled at a non-approved specialty pharmacy provider, they are not a covered benefit. To find out if Your medication is classified as a "specialty" medication, please consult the formulary of medications available at www.chatn.org or contact Customer Service at the number listed on Your ID card.

DURABLE MEDICAL EQUIPMENT

Medically Necessary and Appropriate medical equipment or items that: (1) in the absence of illness or injury, are of no medical or other value to You; (2) can withstand repeated use in an ambulatory or home setting; (3) require the prescription of a Physician for purchase; (4) are approved by the FDA for the illness or injury for which it is prescribed; and (5) are not solely for Your convenience. Covered services include:

- Rental of Durable Medical Equipment. Maximum allowable rental charge is not to exceed the total maximum allowable charge for purchase. If You rent the same type of equipment from multiple Durable Medical Equipment Providers and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, You will be responsible for amounts in excess of the maximum allowable charge for purchase;
- The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment;
- Supplies and accessories necessary for the effective functioning of covered Durable Medical Equipment;
- The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging. Insulin pump replacement is covered for pumps older than 48 months and only if the pump cannot be repaired.

FAMILY PLANNING AND REPRODUCTIVE SERVICES

Medically Necessary and Appropriate family planning services and those services to diagnose and treat diseases that may adversely affect fertility. Covered services include:

- Benefits for (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing; and (5) genetic testing;

- Sterilization procedures;
- Services or supplies for the evaluation of infertility;
- Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting, insertion and removal.

HOME HEALTH CARE SERVICES

Medically Necessary and Appropriate services and supplies provided in Your home by a Provider who is primarily engaged in providing home health care services. Covered services include:

- Part-time, intermittent health services, supplies, and medications, by or under the supervision of a registered nurse;
- Home infusion therapy;
- Rehabilitative therapies such as physical therapy, occupational therapy, etc.;
- Medical social services;
- Dietary guidance.

HOSPICE

Medically Necessary and Appropriate services and supplies for supportive care where life expectancy is 6 months or less. Covered services include:

- Benefits will be provided for: (1) part-time intermittent nursing care; (2) medical social services; (3) bereavement counseling; (4) medications for the control or palliation of the illness; (5) home health aide services; and (6) physical or respiratory therapy for symptom control.

HOSPITAL EMERGENCY CARE SERVICES

Medically Necessary and Appropriate health care services and supplies furnished in a Hospital emergency department that are required to determine, evaluate and/or treat an Emergency until such condition is stabilized, as directed or ordered by the Practitioner or Hospital protocol. Covered services include:

- Medically Necessary and Appropriate Emergency services, supplies and medications necessary for the diagnosis and stabilization of Your Emergency condition;
- Physician services.

INPATIENT HOSPITAL SERVICES

Medically Necessary and Appropriate services and supplies in a Hospital that: (1) is a licensed Acute care institution; (2) provides Inpatient services; (3) has surgical and medical facilities primarily for the diagnosis and treatment of a disease and injury; and (4) has a staff of Physicians licensed to practice medicine and provides 24-hour nursing care by graduate registered nurses. Psychiatric hospitals are not required to have a surgical facility. Covered services include:

- Room and board in a semi-private room (or private room if room and board charges are the same as for a semi-private room);
- General nursing care;
- Medications;
- Injections;
- Diagnostic services;
- Special care units;
- Attending Physician's services for professional care;
- Maternity and delivery services (including routine nursery care and complications of pregnancy). If the hospital or Physician provides services to the baby and submits a claim in the baby's name, benefits may be covered for the baby and mother as separate Subscribers, requiring payment of applicable Copayments, Co-insurance and/or Deductibles.

ORGAN TRANSPLANTS

Medically Necessary and Appropriate services and supplies provided to You, when You are the recipient of the following organ transplant procedures: (1) heart; (2) heart/lung; (3) bone marrow; (4) lung; (5) liver; (6) pancreas; (7) pancreas/kidney; (8) kidney; (9) small bowel; and (10) small bowel/liver. Benefits may be available for other organ transplant procedures that, in the Plan's discretion, are not Experimental or Investigational and that are Medically Necessary and Medically Appropriate. Covered services include:

- Medically Necessary and Appropriate services and supplies at approved locations of service, otherwise covered under this Policy;
- Travel expenses for Your evaluation prior to a covered procedure, and to and from the site of a covered procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes travel expenses for You and a companion. A companion must be Your spouse, family member, or Your guardian;
  - Travel by private care is limited to reimbursement at the IRS mileage rate in effect at the time of travel to and from a facility.
  - Meals and lodging expenses, limited to $150 daily.
  - The aggregate limit for travel expenses is $10,000 per covered procedure.
- Donor organ procurement. If the donor is not a Subscriber, covered services for the donor are limited to those services and supplies directly related to the transplant service itself: (1) testing for the donor's compatibility; (2) removal of the organ from the donor's body;

(3) preservation of the organ; (4) transportation of the organ to the site of the transplant; and (5) donor follow-up care. Services are covered only to the extent not covered by other health coverage. The search process and securing the organ are also covered under this benefit. Complications of donor organ procurement are not covered. The cost of donor organ procurement is included in the total cost of Your organ transplant.

USE OF CENTERS OF EXCELLENCE FOR TRANSPLANT PROCEDURES

The use of a Center of Excellence for transplant procedures **is required** to receive full benefits under the Plan. Call the Plan for complete information on transplant benefits and Centers of Excellence.

OUTPATIENT FACILITY SERVICES

Medically Necessary and Appropriate diagnostics, therapies and Surgery occurring in an outpatient facility that includes: (1) outpatient Surgery centers; (2) the outpatient center of a Hospital; (3) outpatient diagnostic centers; and (4) certain surgical suites in a Physician's office. Covered Services include:

- Physician services;
- Outpatient diagnostics (such as x-rays and laboratory services);
- Outpatient treatments (such as medications and injections);
- Outpatient Surgery and supplies;
- Observation stays less than 24 hours.

PHYSICIAN'S OFFICE SERVICES

Medically Necessary and Appropriate services in a Physician's office. Covered services include:

- Diagnosis and treatment of illness or injury. (Note that allergy skin testing is covered only in the Physician's office setting. Medically Necessary RAST (radioallergosorbent test), FAST (fluorescent allergosorbent test), or MAST (multiple radioallergosorbent test) allergy testing is covered in the Physician's office setting and in a licensed laboratory);
- Injections and medications administered in a Physician's office, except Specialty Drugs. (See Provider Administered Specialty Drugs for information on coverage);
- Second surgical opinions given by a Physician who is not in the same medical group as the Physician who initially recommended the Surgery.

PROSTHETICS/ORTHOTICS

Medically Necessary and Appropriate devices used to correct or replace all or part of a body organ or limb that may be malfunctioning or missing due to: (1) birth defect; (2) accident; (3) illness; or (4) surgery. Covered services include:

- The initial purchase of surgically implanted prosthetic or orthotic devices;
- The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment;
- Splints and braces that are custom made or molded, and are incidental to a Physician's services or on a Physician's order;
- The replacement of covered items required as a result of normal wear and tear, defects or obsolescence and aging;
- The initial purchase of artificial limbs or eyes;
- The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract surgery and obtained within 6 months following the surgery;
- Hearing aids for Subscribers under age 18, as limited herein.

PROVIDER ADMINISTERED SPECIALTY DRUGS

Medically Necessary and Appropriate Specialty Drugs will be covered under the Prescription benefits for the treatment of disease, administered by a Physician or home health care agency and listed as a Physician-administered drug on the Plan's Specialty Drug list. Covered Services include:

- Provider-administered Specialty Drugs, including administration by a qualified Physician.

RECONSTRUCTIVE SURGERY

Medically Necessary and Appropriate Surgical Procedures intended to restore normal form or function. Covered Services include:

- Surgery to correct significant defects from congenital causes, (except where specifically excluded), accidents or disfigurement from a disease state;
- Reconstructive breast Surgery as a result of a mastectomy or partial mastectomy (other than lumpectomy) including Surgery on the non-diseased breast needed to establish symmetry between the two breasts.

SKILLED NURSING CARE

Medically Necessary and Appropriate Inpatient care provided to Subscribers requiring medical rehabilitative or nursing care in a restorative setting. Services shall be considered separate and distinct from the levels of Acute care

rendered in a Hospital setting, or custodial or functional care rendered in a nursing home. Covered services include:

- Room and board in a semi-private room;
- General nursing care;
- Medications;
- Diagnostics;
- Special care units;
- The attending Physician's services for professional care.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Medically Necessary and Appropriate services to diagnose and treat temporomandibular joint syndrome or dysfunction (TMJ or TMD). Covered services include:

- Diagnosis and management of TMJ or TMD;
- Surgical treatment of TMJ or TMD, if performed by a qualified oral surgeon or maxillofacial surgeon;
- Non-surgical TMJ includes: (1) history and exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; (5) medications; and (6) oral appliances to stabilize the jaw joint.

THERAPEUTIC/REHABILITATIVE/ HABILITATIVE SERVICES

Medically Necessary therapeutic, habilitative and rehabilitative services performed in a Physician's office, outpatient facility or home health setting. Covered Services include:

- Outpatient, home health or office therapeutic, habilitative and rehabilitative services that are performed by, or under the direct supervision of a licensed therapist. Must have written authorization of the treating Physician;
- Therapeutic/Rehabilitative /Habilitative Services include: (1) physical therapy; (2) speech therapy; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services. The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Physician's office, outpatient facility or home health setting. Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits. Office visits for care other than actual therapy do not count towards those visit limits.

SUPPLIES

Medically Necessary and Appropriate expendable and disposable supplies for the treatment of disease or injury. Covered Services include:

- Supplies for the treatment of disease or injury used in a Physician's office, outpatient facility or inpatient facility;
- Supplies for treatment of disease or injury that are prescribed by a Physician and cannot be obtained without a Physician's prescription.

VISION

- Medically Necessary and Appropriate diagnosis and treatment of diseases and injuries that impair vision. Covered Services include: services and supplies for the diagnosis and treatment of diseases and injuries to the eye;
- The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract surgery and obtained within 6 months following the surgery;
- Routine vision care for children under 18.

NOTIFICATION

To understand Your costs for a scheduled inpatient admission or select outpatient procedures, You should call the Plan at the number listed on Your Plan ID Card. For a complete list of procedures requiring notification, please visit www.chatn.org.

BENEFIT LIMITS AND EXCLUSIONS

Although the Policy covers most necessary medical expenses, there are some expenses that are not covered. This section outlines exclusions and limits of Your medical coverage. This list is not all-inclusive; if You have questions about a particular service or supply, contact CHA at the number listed on Your ID card.

BENEFIT LIMITS

In addition to the exclusions listed below, refer to the *Schedule of Benefits* section in the Exhibit for the Maximum Individual Limit(s) and any Policy Year limit applicable to certain Covered Expenses. Policy Year limits are met by days/visits/ limits paid under all components of the Health Policy option in which You are enrolled. If You need information, contact CHA at the number listed on Your ID card.

EXPERIMENTAL AND/OR INVESTIGATIONAL

The Plan will not pay for or otherwise cover the cost of drugs or treatments considered Experimental and/or Investigational.

In the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where: (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and Biologics Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or Clinical Pharmacology, United States Pharmacopoeia Drug Information, American Medical Association Drug Evaluations, American Hospital Formulary Service Drug Information, or two articles from major peer reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; or (2) the drug is provided in association with a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute ("NCI") or (3) the drug is provided in association with a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by CHA.

EXCLUSIONS UNDER THE POLICY

No payment will be made under any benefit for expenses incurred in connection with the following, unless specifically stated otherwise in this document.

- Abortions, unless performed in order to save the life of the mother or if the fetus is not viable. Complications from an abortion performed to save the life of the mother are also covered.
- Amounts in excess of any Health Coverage limits.
- Any care connected with military service conditions for which a Subscriber is legally entitled to service and for which facilities are reasonably accessible. This includes any charges incurred while on active duty with the armed Subscriber of any country or international organization.
- Adoption or surrogate expenses.
- Ambulance Services:
  - Transportation for Your convenience;
  - Transportation that is not essential to reduce the of harm to You;
  - Transportation when You are not taken to a Hospital.
- Any care not recommended and approved by a licensed Physician.
- Any Physician or other health professional charges if he or she provides services to herself or to any close relative. Close relative means spouse, domestic partner, brother, sister, parent, grandparent or child and the spouse's or domestic partner's brothers, sisters, parents, grandparent or child.
- Any charges for treatment, services or supplies that are not Medically Necessary or usual for the treatment of an Illness or Injury as determined by CHA's medical staff or an independent medical Physician review panel. This does not apply to qualifying preventive care or other health care services specifically covered under the Policy that are not required to preserve Your health.
- Any dental care, treatment, implants, surgery, or supplies, except for the following:
  - repair started within 3 months of accidental injuries and completed within 12 months to

sound natural teeth caused from being accidentally struck from outside the mouth and while covered under the Plan; or

- inpatient hospital and anesthesia expenses related to dental work if the primary reason for such confinement (inpatient or outpatient) is deemed to be an underlying serious and hazardous medical condition.

- Any diagnostic admission to a facility if the test can be performed in a less restrictive or dangerous environment on an outpatient basis.
- Any Illness or Injury for which benefits or payments are received (or could be received if claims were made) under any workers' compensation law, employer's liability law or similar act.
- Any Illness or Injury for which any benefits are received or could be received if claims were made under any automobile insurance policy to the extent that the policy provides benefits for covered Subscriber under the Policy.
- Any treatment, equipment, drug or device that does not meet generally accepted standards of practice in the medical community supported in the peer reviewed medical literature.
- Arch supports, foot orthotics that cost more than $500 or are not prescribed by a Physician, and orthopedic shoes, such as biomechanical evaluation, range of motion measurements and reports, and negative mold foot impressions, unless the shoe is an integral part of a brace or when required following surgery or is a part of the initial care for treatment of a Medically Necessary condition.
- Augmentative communications devices.
- Autopsies.
- Balloon sinuplasty for treatment of chronic sinusitis.
- Behavioral health conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.
- Blepharoplasty, rhinoplasty, abdominoplasty, browplasty, or other cosmetic procedures.
- Charges for duplicating and obtaining medical records.
- Charges for or related to fetal tissue transplants.
- Charges related to organ transplants except as specified in the section entitled, *Organ, Bone Marrow and Tissue Transplants*.
- Charges relating to surrogate pregnancy, including but not limited to maternity and delivery charges, whether or not the surrogate mother is covered under this Policy.
- Charges for artificial organs or systems used to assist or replace a natural body organ (such as an artificial heart) and any related Subscriber or supplies. Note: Artificial support machines while awaiting a human organ or tissue transplant and other approved devices such as pacemakers and kidney dialysis machines are eligible.
- Charges for reconstructive surgery relating to aesthetic appearance and related Subscriber, except for the following:
  - reconstructive surgery and related charges following a covered mastectomy;
  - surgery to repair a defect caused by an accidental Injury resulting in a functional impairment;
  - reconstructive surgery related to an Injury, Sickness, or other disease of that part of the body;
  - reconstructive surgery following surgery that was needed due to an Injury, Sickness, or other disease of that part of the body;
  - cosmetic or reconstructive surgery or treatment to repair a Dependent child's congenital malformation or developmental defect.
- Charges for telephone calls with the office of a health professional for the failure to keep a scheduled visit, mailing, shipping and handling expenses, completing any form, for medical information, or other administrative service.
- Telephonic and interactive electronic interchanges (e-visits) between in network licensed practitioners and Subscribers with documentation of clinical assessments and recommendations are eligible services.
- Charges for the treatment of compulsive gambling.
- Charges that exceed the allowed amounts and/or the Usual and Customary Charge or the Usual and Customary Charge.
- Charges in excess of the Maximum Allowable Charge for Covered Services.
- Charges for Gastric bypass, roux-en-Y, duodenal switch, sleeve gastrectomy, laparoscopic lap band. Any new or related procedures done for the

purpose of weight reduction, elimination of obesity or the co-morbidities of obesity are also excluded.

- Charges for a drug, device, diagnostic or screening procedure, or a medical treatment or procedure of an Experimental or Investigative nature or an Unproven Service as determined by CHA. This does **not** include drugs that: a) have been granted investigational new drug (IND) or Group C/treatment IND status; b) are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or c) for which available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease as determined by CHA. In the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where: (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and Biologics Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or Clinical Pharmacology, United States Pharmacopoeia Drug Information, American Medical Association Drug Evaluations, American Hospital Formulary Service Drug Information , or two articles from major peer reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; or (2) the drug is provided in association with a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute ("NCI") or (3) the drug is provided in association with a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by CHA.
- Charges for handling fees.
- Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
- Chelation therapy, except for (1) control of ventricular arrhythmias or heart block associated with digitalis toxicity; (2) emergency treatment of hypercalcemia; (3) extreme conditions of metal toxicity, including thalassemia with hemosiderosis; (4) Wilson's disease (hepatolenticular degeneration); and (5) lead poisoning.
- Cosmetic Services, except as appropriate per medical policy. This exclusion applies to surgeries to improve appearance following a prior surgical procedure, even if that prior procedure was a Covered Service. Cosmetic Services include, but are not limited to: (1) removal of tattoos; (2) facelifts; (3) keloid removal; (4) dermabrasion; (5) chemical peels; (6) breast augmentation; (7) lipectomy; (8) body contouring or body modeling; (9) injections to smooth wrinkles, including but not limited to, Botox; (10) laser resurfacing; (11) sclerotherapy injections, laser or other treatment for spider veins and varicose veins; (12) piercing ears or other body parts, (13) rhytidectomy or rhytidoplasty (surgery for the removal or elimination of wrinkles); (14) rhinoplasty; (15) panniculectomy/abdominoplasty; (16) thighplasty; (17) brachioplasty.
- Court ordered examinations and treatment, unless Medically Necessary.
- Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly.
- Custodial care or home care that includes services to assist in activities of daily living and personal care which do not seek to cure or do not need to be provided by a skilled medical professional.
- Dental Services:
    - Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) tooth extraction; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth;
    - Treatment for correction of underbite, overbite, and

misalignment of the teeth including, but not limited to, braces for dental indications, orthognathic surgery, and occlusal splints and occlusal appliances to treat malocclusion/misalignment of teeth;

- Extraction of impacted teeth, including wisdom teeth.

- Diabetes Treatment:
  - Treatments or supplies that are not prescribed and certified by a Provider as being Medically Necessary.
- Diagnostic Services:
  - Diagnostic services that are not Medically Necessary and Appropriate;
  - Diagnostic services that are not ordered by a licensed Provider.
- Durable Medical Equipment:
  - Charges exceeding the total cost of the maximum allowable charge to purchase the equipment;
  - Unnecessary repair, adjustment or replacement or duplicates of any such equipment;
  - Supplies and accessories that are not necessary for the effective functioning of the covered equipment;
  - Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology;
  - Items that require or are dependent on alteration of home, workplace or transportation vehicle;
  - Motorized scooters, exercise equipment, hot tubs, pools and saunas;
  - "Deluxe" or "enhanced" equipment. Basic equipment that will provide the Medically Necessary intervention will determine the benefit;
  - Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs and seat lifts of any kind;
  - Patient lifts, auto tilt chairs, air fluidized beds, or air flotation beds, unless approved as medically necessary;
  - Portable ramp for a wheelchair.
- Enteral feeding formulas, except for the following:
  - prescription and over the counter enteral feeding formulas when considered a sole source of nutrition and given via a feeding tube. This includes tube feeding supplies; or
  - oral prescription enteral formulas when considered a sole source of nutrition. Over the counter enteral feeding formulas are not covered when given orally.
- Expenses for care or treatment received outside the United States or its territories, except for unexpected, emergency situations while traveling or while on short or long-term international assignment.
- Expenses used to satisfy Policy Deductibles and/or coinsurance.
- Expenses eligible for consideration under any other policy, including Medicare.
- Expenses not specifically listed as Covered Expenses under this Policy.
- Expenses incurred as a result of Your being drunk or under the influence of any controlled substance unless taken in accordance with the advice of a Physician for medically necessary care.
- Family Planning and Reproductive Services:
  - Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology; (6) fertility injections; (7) fertility drugs; services for follow-up care related to infertility treatments;
  - Services or supplies for the reversals of sterilizations;
  - Sperm preservation;
  - Induced abortion unless: the health care provider certifies in writing that the pregnancy would endanger the life of the mother or the fetus is not viable.
- Full body scans, EBCT (heart scans).
- Gene therapy as a treatment for inherited or acquired disorders.
- Homeopathic visits.
- Health services needed from attempting to commit or committing a felony, or engaging in an illegal occupation.
- Health services performed before the effective date or after the end of coverage under this Policy.
- Hearing aids for Subscribers age 18 or older.
- Home construction needed for the installation of special, medically necessary equipment.

- Home Health Care Services:
  - Items such as non-treatment services;
  - Routine transportation;
  - Homemaker or housekeeping Subscriber;
  - Behavioral counseling;
  - Supportive environmental equipment;
  - Maintenance care or custodial care;
  - Social casework;
  - Meal delivery;
  - Personal hygiene; and
  - Convenience items.
- Hospice Care:
  - Unapproved Inpatient services;
  - Services such as: (1) homemaker or housekeeping services; (2) meals; (3) convenience or comfort items not related to the illness; (4) supportive environmental equipment; (5) private duty nursing; (6) routine transportation; and (7) funeral or financial counseling.
- Hospital Emergency Care Services:
  - Treatment of a chronic, non-Emergency condition, where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency;
  - Services received for inpatient care or transfer to another facility once Your medical condition has stabilized, unless prior authorization is obtained from CHA within 24 hours or the next working day.
- Hypnosis or regressive hypnotic techniques.
- Inpatient Hospital Services:
  - Inpatient stays primarily for therapy (such as physical or occupational therapy) that can be safely and effectively provided in less restrictive and risky environments;
  - Services that could be provided in a less restrictive environment at less cost to Subscriber and Insurer;
  - Private room when not authorized by CHA and room and board charges are in excess of semi-private room;
  - Blood or plasma that is provided at no charge to the patient.
- Illness or Injury resulting from war, that occurred before Your coverage began under this Policy and that is covered by: (1) veteran's benefit; or (2) other coverage for which You are legally entitled.
- Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil.
- Lenses, frames and contact lenses; other fabricated optical devices or related professional services including the treatment of refractive errors such as radial keratotomy and laser refractive surgery regardless of medical condition, except when determined to be Medically Necessary following cataract surgery.
- Liposuction or Lipotherme.
- Marriage counseling.
- Maternity expenses for Dependents unless there are life threatening complications.
- Medical services or products purchased outside of the U.S., unless in an unexpected, emergency situation.
- Organ Transplants:
  - Services or supplies not specified as Covered Services;
  - Any attempted covered procedure that was not preformed, except where such failure is beyond Your control;
  - Non-covered services;
  - Services that would be covered by any private or public research fund, regardless of whether You applied for or received amounts from such fund;
  - Any non-human, artificial or mechanical organ;
  - Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;
  - Any service that requires Prior Authorization and authorization is not received;
  - Removal of an organ from a Subscriber for purposes of transplantation into another person, except as described herein;
  - Harvest, procurement and storage of stem cells, whether obtained from peripheral blood, cord blood or bone marrow when reinfusion is not scheduled or anticipated to be scheduled within an appropriate time frame for the patient's covered stem cell transplant diagnosis;
  - Other non-organ transplants (e.g. cornea).

- Prescription drugs that have not been classified as effective by the FDA; bio-engineered drug therapy that has not received FDA approval for the specific use being requested; prescription drugs that are not administered according to generally accepted standards of practice in the medical community.
- Prosthetics or Orthotics:
  - Hearing aids for Subscribers age 18 or older;
  - Prosthetics primarily for cosmetic purposes, including, but not limited to: wigs, or other hair prosthesis or transplants;
  - Items to replace those that were lost, damaged, stolen, or prescribed as a result of new technology;
  - The replacements of contacts after the initial pair have been provided following cataract surgery;
  - Foot orthotics, shoe inserts and custom made shoes except as required by law for diabetic patients or as part of a leg brace.
- Non-prescription drugs or medicines, except for those which appear on theFormulary as a Covered Benefit and are prescribed by a licensed Provider.
- Non-emergency admissions greater than 24 hours in advance of procedure unless specified by Your Physician.
- Non-medical counseling or training services.
- Treatment by artificial means for the purpose of causing a pregnancy, such as but not limited to: prescription drugs, donor ova and sperm and artificial or intrauterine insemination procedures, assisted reproductive technology (ART) procedures, including, but not limited to, in vitro fertilization (IVF), gamete intracryopreservation or frozen embryo transfer.
- Outpatient Facility Services:
  - Rehabilitative therapies in excess of the terms of the Therapeutic/Rehabilitative benefit;
  - Services that could be provided in a less intensive setting.
- Personal comfort items while Hospitalized such as telephone or television; Hospital room and board expenses that exceed the semi-private room rate unless a private room is approved as Medically Necessary.
- Physician Office Services:
  - Office visits, physical exams and related immunizations and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings;
  - Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) calluses; (4) toenails; (5) fallen arches; and (6) weak feet or chronic foot strain;
  - Rehabilitative therapies in excess of the limits of the Therapeutic/Rehabilitative/ Habilitative benefit;
  - Dental procedures, except as otherwise indicated in this Policy.
- Physician charges for injections that can be self-administered.
- Phototherapy devices for Seasonal Affective Disorder.
- Private duty nursing services.
- Provider Administered Specialty Drugs:
  - Self-administered Special Drugs;
  - FDA-approved drugs used for purposes other than those approved by the FDA, except as provided herein.
- Reconstructive Surgery:
  - Services, supplies or prosthetics primarily to improve appearance;
  - Surgeries to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance, and surgeries to improve appearance following a prior surgical procedure, even if that prior procedure was a covered service;
  - Surgeries and related services to change gender (transsexual surgery).
- Recreational or educational therapy or forms of non-medical self-care or self-help training including health club memberships, weight loss programs, biofeedback, behavior modification therapy and any related servicesor diagnostic testing.
- Reversal of sterilization.
- Routine physical exams and immunizations for employment, travel or insurance purposes.
- Safety items, or items to affect performance primarily in sports-related activities.
- Sales tax.
- Self-treatment or training.
- Services of the clergy.
- Services that are prohibited by law or regulations.
- Services or confinements ordered by a court or law enforcement officers that are determined not Medically Necessary (an initial court-ordered exam for a

Dependent child under age 18 years is considered Medically Necessary).

- Services rendered by anyone other than a healthcare Provider. Services provided mainly for rest cures, the ease of a household, or sanitarium care.
- Services or supplies for common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers, allergenic mattresses, computer equipment and related devices, or supplies of a similar nature, whether or not prescribed by a Physician.
- Services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group.
- Services or supplies for Maintenance Care.
- Services or supplies related to treatment of complications (except complications of pregnancy) that are a direct or closely related result of a Subscriber's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician.
- Services or supplies that are determined to be not Medically Necessary.
- Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to, erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.
- Services for, or related to, systemic candidiasis, multiple chemical sensitivities, homeopathy, immunoaugmentative therapy or chelation therapy determined to be not Medically Necessary.
- Services, supplies, chemotherapy, drugs and aftercare for or related to an organ, tissue, or bone marrow transplant or stem cell transplant that is not covered.
- Services related to mental retardation.
- Services that are free.
- Skilled Nursing/Rehabilitative Facility Services:
  - Custodial, home or private duty nursing services;
  - Skilled nursing services not received in a Medicare certified skilled nursing facility;
  - Services for cognitive rehabilitation.
- Sleep disorders.
- Staff consultations required by hospital or other facility rules.
- Supplies that can be obtained without a prescription (except for diabetic supplies).
- Temporomandibular Joint Dysfunction (TMJ) – The following Subscriber sometimes associated with TMJ are not covered under the Policy's medical benefits:
  - Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) tooth extraction; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth;
  - Treatment for correction of underbite, overbite, and misalignment of the teeth including braces for dental indications.
- Therapeutic/Rehabilitative Services:
  - Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state;
  - Complementary and alternative therapeutic services, including, but not limited to: (1) massage therapy; (2) acupuncture; (3) craniosacral therapy; (4) cognitive rehabilitation; (5) vision exercise therapy; and (6) neuromuscular reeducation. Neuromuscular reeducation refers to any form of athletic training, rehabilitation program or bodily movement that requires muscles and nerves to learn or relearn a certain behavior or specific sequence of movements. Neuromuscular reeducation is sometimes performed as part of a physical therapy visit;
  - Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to: (1) activities that are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that You can perform without a

therapist in a home setting; (5) routine dressing changes; and (6) custodial services that can ordinarily be taught to You or a caregiver;

- Behavioral therapy, play therapy, communication therapy, and therapy for self correction language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs;
- Duplicate therapy. For example, when You receive both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

- Travel and/or lodging expenses of a Physician or a patient, except as specified in the organ transplant section.
- Treatment for benign gynecomastia.
- Treatment for hyperhidrosis.
- Treatment while confined in a state, federal or Veterans Administration Hospital for which charges are not imposed.
- Transportation other than local ambulance service for a medical emergency to the nearest Hospital that can provide care. Air ambulance covered if only reasonable means of transport available.
- Vagus nerve stimulation for the treatment of depression.
- Vision:
  - Routine vision Subscriber for adults over age 19, including Subscriber, surgeries and supplies to detect or correct refractive errors of the eyes;
  - Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses;
  - Eye exercises and/or therapy;
  - Visual training.
- Vocational and educational training services except approved diabetic education programs, cardiac rehabilitation, pre-term birth prevention for high risk pregnancies, asthma, or cancer programs.

DESCRIPTION OF IN-NETWORK AND OUT-OF-NETWORK UNDER THE HEALTH POLICY

This section includes information about how In-Network and Out-of-Network Benefits work and how Emergency Services are covered.

IN-NETWORK BENEFITS

In-Network benefits are generally paid at a higher level than Out-of-Network Benefits. In-Network Benefits are payable for Covered Expenses which are:

- Provided by a Network Physician or other Network Provider, or
- Considered to be an Out-of-Network Benefit exception.

Payment for In-Network Benefits are based on the Network Provider's negotiated rates with the Plan.

PROVIDER NETWORK

CHA arranges for health care Providers to participate in a Network. Network Providers are not CHA employees. It is Your responsibility to select Your Primary Care Provider.

There is no assurance as to the quality of the services provided.

Before obtaining services, You should verify the network status of a Provider. A Provider's status may change. You are responsible for checking a Provider's Network status prior to receiving services, even when You are referred by another Network Provider. You can verify the Provider's status by calling CHA at the number on Your ID card.

It is possible that You might not be able to obtain services from a particular Network Provider. The network of Providers is subject to change. Or, You might find that a particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network Benefits.

Do not assume that a Network Provider's agreement includes all Covered Services. Some Network providers agree to provide only certain Covered Services, but not all Covered Services. Some Network Providers choose to be a Network Provider for only some products. For example, an OB/GYN may decide to stop deliviering babies. You may contact CHA at the number on Your ID card for help in choosing a Provider or with questions about a particular Provider's Network participation.

OTHER PROVIDERS

For special services, CHA may direct You to a Provider it chooses. If You require certain complex Covered Services for which expertise is limited, CHA may direct You to an Out-of-Network Provider.

In both cases, benefits will only be available if the chosen Provider renders services for that condition.

OUT-OF-NETWORK BENEFITS

This Policy does not cover Out-of-Network services except for emergencies or as explained above.

WHAT IF I'M TRAVELING AND NEED MEDICAL CARE?

If you are traveling outside your network and you need medical care, you should contact Customer Service at the number on Your ID card or log onto www.chatn.org for help locating the nearest Network Provider. If you need Emergency Care, however, go ahead and get the care you need.

EMERGENCY CARE

This Policy provides benefits for Emergency Care when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

In-Network Benefits are paid for Emergency Care, even if the services are provided by an Out-of-Network Provider.

CONFINEMENT IN AN OUT-OF-NETWORK HOSPITAL FOLLOWING AN EMERGENCY

If You are confined in an Out-of-Network Hospital after You receive Emergency services, , **You must notifiy CHA within two (2) business days or on the same day of admission if reasonably possible.** CHA may elect to transfer You to a Network Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Out-of-Network Hospital after the date CHA decides a transfer is medically appropriate, Out-of-Network Benefits may be available.

OTHER EXCEPTIONS

If, while an Inpatient or receiving Outpatient services, You have an x-ray, receive laboratory services, or anesthesia services from an Out-of-Network Provider while You are in an In-Network facility, we will cover the service at the In-Network benefit level.

CLAIMS PROCEDURES UNDER THE HEALTH POLICY

Claims are processed according to the benefits of the Policy You selected. Please review Your Schedule of Benefits for further information on Your Policy. You can also visit our website at www.chatn.org or call Customer Service for further details on Your Policy selection.

HOW CLAIMS ARE PROCESSED

When You receive care from Your health care Provider, You will present Your ID card. Your Provider should submit a claim for payment directly to CHA. If Your Provider does not file a claim on Your behalf, follow the procedures below.

SUBMITTING A CLAIM

At times You may be responsible for submitting a claim directly to CHA. All claims should be mailed to CHA. You may get claim forms from our web site through our Subscriber portal at www.chatn.org or by calling the Customer Service number on Your ID card.

For information on how to file a claim for pharmacy benefits, contact Customer Service.

You must submit Your claims to the Plan within 15 months of the date of service. Benefits for Your service can be denied or reduced, at the Plan's discretion, if not received timely.

REQUIRED INFORMATION

Provide the following information when submitting Your claim form:

- Your name, date of birth and address;
- The patient's name, if different from the policy holder, date of birth and family relationship to You;
- The Subscriber number stated on Your ID card; and
- An itemized bill from Your provider that includes the following:
  - Patient Diagnosis
  - Date(s) of service
  - Procedure Code(s) and descriptions of service(s) rendered
  - Charge for each service rendered
  - Provider of service Name, Address and Tax Identification Number.

Note: When submitting Your claim, You must also include a receipt showing proof of payment.

Submit Your claims to the address appearing on the back of Your identification card.

PROVIDING AUTHORIZATION

You have agreed that a Provider may provide the needed information about the care they provide to You. The Insurer keeps all such information strictly confidential. If a Provider requires specific authorization to release records, You agree to provide this authorization. Your failure to provide authorization or requested information may result in denial of Your claim.

CLAIMS PAYMENTS

Payments will be made directly to the Providers who have submitted a claim to CHA on Your behalf.

Payments for manually submitted claims or Out-of-Network claims will be made to You unless either of the following is true:

- The Provider notifies CHA that Your signature is on file, assigning benefits directly to that Provider.
- You make a written request for the Out-of-Network Provider to be paid directly at the time You submit Your claim.

When Your claims are processed, You will receive a notice of the action taken by CHA in the form of an Explanation of Benefits or EOB. The EOB provides the details of how CHA processed the claim. For example, it will show how much CHA paid Your Provider, the procedures performed, the date the service was performed, and the amount of money You may owe the Provider, if any.

The EOB will also show if CHA did not process or pay Your claim. In some cases, more information may be needed or is requested to complete the cycle for claim payment; or the claim may be denied payment by CHA. The EOB will state the specific reason or reasons for the denial, refer to specific Policy provisions on which the denial is based, contain any information necessary for the claim to be processed and an explanation of why such information is necessary. This letter will also describe the process for filing a formal appeal and the time limits for filing an appeal, including Your right to bring a civil action following an adverse determination upon appeal. If the denial is based on Medical Necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of Your Policy to

Your medical circumstances. The denial notice will also contain the internal rule, guideline or protocol that was relied on, if applicable.

QUESTIONS AND APPEALS

This section provides You with the information to help You with the following:

- You have a question or concern about the Covered Service or Your benefits.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Policy and You wish to appeal such determination.

Nothing will prevent You from filing a complaint with the Tennessee Department of Commerce and Insurance. However, such complaints are separate from and in addition to CHA's Appeals processes.

To resolve a question or appeal, just follow these steps:

WHAT TO DO FIRST

If Your question or concern is about a benefit determination, please contact Customer Service before requesting a formal appeal. CHA has staff that is dedicated to resolving difficult customer concerns. If we are unable to resolve the issue to Your satisfaction, please review and follow the instructions listed in next section titled *How to File an Appeal*.

Customer Service is available to take Your call during regular business hours, Monday through Friday from 8am to 6pm.

HOW TO FILE AN APPEAL

If You disagree with a benefit determination after following the above steps, You can contact Customer Service in writing or over the phone to formally request an appeal. Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The Provider's name.
- The reason You believe the claim should be paid.
- Any documentation or other written information to support Your request for claim payment.

Your internal appeal request must be submitted to CHA within 180 days after You receive notification of the benefit determination that You disagree with.

APPEAL PROCESS

An individual who was not involved in the decision being appealed will be appointed to decide the appeal. If Your appeal is related to clinical matters, the review will be done with a health care professional with expertise in the field who was not involved in the prior decision. CHA may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon written request and free of charge, You have the right to reasonable access to and copies of, all documents, records, and other information relevant to Your claim for benefits.

APPEALS DETERMINATIONS

You will be provided written or electronic notification of the decision on Your appeal.

The internal appeal will be conducted and You will be notified of the decision within a reasonable time given Your medical condition, but not later than 60 days from receipt of Your request. Prior to the internal appeal decision, You will be notified of Your right to:

- Submit written documents, records and other materials relating to the request for benefits as well as have access to, and copies of all documents, records and other information, free of charge, which are relevant to Your request for benefits;
- Request, within a reasonable amount of time, the opportunity to appear in person before a review panel of designated representatives;
- Present Your case to the review panel;
- If applicable, to ask questions of any representatives on the review panel; and
- Be assisted or represented by an individual of Your choice, at Your own expense.

- For urgent procedures, see *Urgent Appeals that Require Immediate Action* below.

If Your appeal is denied, You will receive a notice explaining the following: the reason for the denial, specific references to the part of the Policy on which the denial is based, a statement that You are entitled by law to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim, a statement regarding any voluntary appeal procedures offered by the Policy and Your right to bring a civil action after an adverse determination on appeal, information about the internal rule, guideline or protocol that was relied on, if applicable, and information on the scientific or clinical judgment for the decision if the adverse decision

is based on medical necessity or experimental treatment.

URGENT APPEALS THAT REQUIRE IMMEDIATE ACTION

Your appeal may require immediate action if it involves an adverse decision about admission, availability of care, continued stay, or healthcare services when You received Emergency services but have not yet been discharged. In these urgent situations:

- The appeal does not need to be submitted in writing. You or Your Physician may request an expedited internal appeal orally or electronically.
- You will be provided with all documents and information being considered in the expedited appeal by phone, email, fax, or other reasonable means.
- CHA will provide You with a decision as expeditiously as Your condition requires, but not more than 72 hours following CHA's receipt of Your urgent appeal request.
- You can pursue an Expedited External Review while simultaneously pursuing an Expedited (Urgent) Internal appeal.

STANDARD EXTERNAL REVIEW

You may request a standard external review if:

- You have exhausted the internal review processes documented above under *Appeal Determinations*; or
- CHA has not provided You with a determination on Your internal appeal within the applicable time frame; and
- The request for external review is received within 6 months of the final internal Adverse Determination.

External review is available if the decision to deny benefits is based on one of the following:

- Lack of Medical Necessity
- Failure to meet requirements with regard to appropriateness, setting, level of care, or effectiveness; or
- The exclusion for Experimental, investigational or Unproven services or treatment and Your condition is life threatening or seriously disabling; or
- A rescission of coverage

CHA will notify You, within 3 business days of Your request for external review, whether Your request is eligible for external review. CHA will also instruct You on how to submit documentation for Your appeal.

If Your appeal is eligible for external review, CHA will send Your request to an Independent Review Organization (IRO) at its own cost.

A decision will be made on Your external review within 45 days from the date of Your request.

The IRO's decision will be binding and there will be no other review.

EXPEDITED EXTERNAL REVIEW

You may request an expedited external review if:

- The denial involves a medical condition where the time frame for a standard external review would seriously jeopardize Your life or health or Your ability to regain maximum function; or
- The denial was based upon a determination concerning an admission, availability of care, continued stay, or health care service for which You received emergency care and have not been discharged from a Facility.

If Your appeal is not eligible for an expedited external review, You will be notified in writing.

If Your appeal is eligible for an expedited external review, CHA will immediately send Your request to an IRO at its own cost.

A decision will be made on Your expedited external review as quickly as Your medical condition or circumstances require, but no more than 72 hours from the time of Your request.

The decision made by the IRO will be binding and there will be no other review.

EXAMINATION AND AUTOPSY

CHA, at its own expense, may examine the Subscriber for whom a claim is made as often as reasonably necessary while a claim is pending, and in cases of death of the Subscriber, may have an autopsy performed during the period of contestability and unless prohibited by law.

SUBROGATION

SUBROGATION AND THIRD PARTY RECOVERY

Subrogation applies to situations where the Insured is injured and another party is responsible for payment of health care expenses (s)he incurs because of the injury. The other party may be an individual, insurance company or some other public or private entity. Automobile accident injuries or personal injury on another's property are examples of cases frequently subject to subrogation.

The Subrogation provision allows for the right of recovery for certain payments. Any payments made for the Insured's injuries under the Policy may be recovered from the other party. Any payments made to the Insured for such injury may be recovered from the Insured from any judgment or settlement of his or her claims against the other party or parties.

By accepting Coverage under the Policy, the Insured automatically assigns to CHA any rights the Insured may have to recover all or part of any payments made by CHA from any other party, including an insurer or another group health program. Therefore, CHA may act as the Insured's substitute in the event any payment made by this Policy for health care benefits that is or becomes the responsibility of another party. Such payments shall be referred to as Reimbursable Payments. This assignment allows CHA to pursue any claim that the Insured may have, whether or not the Insured chooses to pursue that claim.

The Insured must cooperate fully and provide all information needed under the Policy to recover payments, execute any papers necessary for such recovery, and do whatever else is necessary to secure such rights to CHA. The other party may be sued in order to recover the payments made for the Insured under the Policy.

RIGHT OF REIMBURSEMENT AND RECOVERY

Specifically, by accepting Coverage under the Policy the Insured agrees that if the Insured receives any recovery in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a tortfeasor, (2) a liability insurer for a tortfeasor, or (3) any other source, including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverages, workers' compensation coverage, premises liability coverage, any medical malpractice recovery, or any other form of insurance coverage ("Recovery"), the Insured must repay CHA in full for any medical benefits and expenses which have been paid or which will in the future be payable under the Policy for expenses already incurred or which are reasonably foreseeable at the time of such Recovery.

CHA has an equitable lien against the Recovery rights of the Insured and has the right to be paid from any such Recovery any and all monies specifically designated as medical expenses and that: (1) is paid; (2) payable to; or (3) for the benefit of, the Insured to the extent of the Policy pays medical benefits and expenses and CHA is the primary issuer. ("Subrogated Amount"). CHA shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of CHA, CHA may reduce any future Eligible Expenses otherwise available to the Insured under the Policy by an amount up to the total amount of Subrogated Amount that is subject to the equitable lien. All rights of recovery will be limited to the amount of payments made under this Policy.

CHA may, in its sole discretion, require the Insured, as a pre-condition to receiving benefit payments, to sign a subrogation agreement and to agree in writing to assist CHA to secure CHA's right to payment of the Subrogation Amount from the third party. In the event that CHA does not receive payment of the Subrogated Amount, CHA may, in its sole discretion, bring legal action against the Insured or reduce or set-off the unpaid Subrogated Amount against any future benefit payments to the Insured. If CHA takes legal action to enforce its subrogation rights, CHA shall be entitled to recover its attorneys' fees and costs from the Insured.

The following provisions apply to CHA's right of subrogation, reimbursement, and creation of an equitable lien:

1. **"Pay and Pursue."** CHA has elected the "pay and pursue" option in connection with the subrogation, reimbursement and equitable lien rights for claims involving Covered Services. Pursuant to the election of "pay and pursue," benefit payments will be made prior to applying the subrogation, reimbursement and equitable lien rights under the Policy.

2. **Scope of Subrogation,**

Reimbursement and Equitable Lien Rights. The subrogation, reimbursement and equitable lien rights apply to any medical benefits paid by CHA on behalf of the Insured as a result of the Injuries sustained, including, but not limited to:

a. Any no-fault insurance;
b. Medical benefits coverage under any automobile liability Plan. This includes the Insured's Plan or any third party's policy under which the Insured is entitled to benefits;
c. Under-insured and uninsured motorist coverage;
d. Any automobile medical payments and personal injury protection benefits;
e. Any third party's liability insurance
f. Any premises/guest medical payments coverage;
g. Any medical malpractice recovery;
h. Workers' compensation benefits. The right of subrogation, reimbursement and equitable lien attach to any right to payment for workers' compensation, whether by judgment or settlement, where CHA has paid expenses otherwise eligible as Covered Services prior to a determination that the Covered Services arose out of and in the course of employment. Payment by Workers' Compensation insurers or the employer will be deemed to mean that such a determination has been made.
i. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds).

4. **Excess Payments.** If CHA erroneously makes total payments that exceed the maximum amount to which the Insured is entitled at any time under the Policy, CHA shall have the right to recover the excess amount from any persons to, or for, or with respect to whom such excess payments were made.

5. **Reduction of Future Benefits.** The Policy provides that recovery of excess amounts may include a reduction of future benefit payments available to the Insured under the Policy of any amount up to the aggregate amount of Reimbursable Payments that have not been reimbursed by CHA.

6. **No Deductions for Costs or Attorneys' Fees.** The reimbursement required under CHA shall not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by CHA at the exercise of its sole discretion.

GENERAL INFORMATION

GENERAL INFORMATION

GUARANTEED RENEWABILITY

This Policy will remain in effect so long as You pay Your Premiums. The Policy will be automatically renewed except for the specific events stated in this Policy.

CREDITABLE COVERAGE UNDER HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Your Insurer must issue a "certificate of creditable coverage", in writing, free of charge:

- when You lose coverage under the Policy;
- if You request a certificate of credible coverage before losing coverage; or
- if You request a certificate of credible coverage up to twenty-four (24) months after losing coverage.

"Creditable Coverage" means health care coverage under any of the types of plans listed below, during which there was no break in coverage of sixty-three (63) consecutive days or more:

- a group health plan;
- health insurance coverage;
- Medicare;
- Medicaid;
- medical and dental care for members and certain former members of the uniformed Subscriber, and for their Dependents;
- a medical care program of the Indian Health Services Program or a tribal organization;
- a state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- The State Children's Health Insurance Program (S-CHIP);
- health plans established and maintained by foreign governments or political subdivisions and by the U.S. government;
- any health coverage provided by a governmental entity;
- any public health benefit program provided by a state, county, or other political subdivision of a state; or
- a health benefit plan under the Peace Corps Act.

If You or Your eligible Dependents were covered by any of the above plans before first becoming covered by this Policy, You should have received a Certificate of Creditable Coverage when that plan's coverage ended.

You may request a certificate of creditable coverage under this Policy by contacting CHA at the number on Your ID card.

PRIVACY NOTICE FOR THE POLICY

The Privacy Notice describes how medical information about You may be used and disclosed and how You can get access to this information. Please review the notice carefully.

HIPAA PRIVACY NOTICE

This Privacy Notice describes how CHA may use and disclose Your health information to carry out treatment, payment and health care operations and for other uses and disclosures that are required or permitted by law. If You receive benefits under any of these components of this Policy, this Privacy Notice explains Your rights with respect to Your health information, and certain obligations CHA must abide by in accordance with the law.

CHA is required by law to maintain the privacy of Your health information and to provide You with this Privacy Notice outlining its legal duties and privacy practices with respect to Your health information. Nothing contained in this Privacy Notice should be construed to supersede or limit any rights You may be entitled to under other applicable law. Therefore, if an applicable law affords You greater rights or more protections other than as described herein, the Health Policy will comply with the law that gives You greater rights and/or protections.

CHA is required to abide by the terms of this Privacy Notice, but reserves the right to make changes to this Privacy Notice and to make such changes applicable to all of Your health information that it maintains. If the Health Policy makes any material revisions to this Privacy Notice, it will provide You with a copy of the revised Privacy Notice which will specify the date on which such revised Privacy Notice becomes effective.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

CHA may use Your health information for treatment, payment and health care operations. CHA may also use Your health information for other purposes that are permitted and/or required by law and pursuant to Your written authorization.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), CHA will be required to limit its distribution, use or requests for protected health information, to the extent practicable, to a limited data set, or if more information is needed, to the minimum necessary amount of information needed to accomplish the intended purpose of the data use. The Secretary of HHS shall issue guidance on what constitutes minimum necessary for the purposes of this provision no later than 18 months following the enactment date. The enactment date is February 17, 2009.

The following lists examples of how the Health Policy may use and/or disclose Your health information. Any other uses or disclosures not described in this Privacy Notice will only be made with Your explicit written authorization. You may revoke this authorization at any time by providing CHA with written notice of Your revocation.

A. For Treatment.
CHA may disclose Your health information to a health care Provider that treats You. For example, in an emergency situation, CHA may give Your health care Provider information regarding the type of Prescription Drugs You are currently taking if necessary for Your proper treatment.

B. For Payment.
CHA may use Your health information to obtain premium payments or to fulfill its responsibility for coverage and the provision of benefits under the Policy. For example, CHA may receive and maintain information about a health care service You received in order to process a claim from a physician for reimbursement for services provided to You.

C. For Health Care Operations.
CHA may also disclose Your health information for management functions. For example, CHA may use and/or disclose Your health information to evaluate its performance or to conduct or arrange for legal servicer and audit functions, including fraud and abuse detection and compliance programs. CHA may use Your health information for its business management and general administrative activities, including but not limited to: (i) management activities relating to implementation of and compliance with law; (ii) customer service; (iii) resolution of internal grievances; (iv) the sale, transfer, merger, or consolidation of all or part of CHA with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and (v) creating de-identified information or a limited data set.

D. For Treatment Alternatives.
CHA may use and disclose Your health information to tell You about treatment options or alternatives that may be of interest to You.

E. For Health-Related Benefits and Services.
CHA may use and disclose Your health information to tell You about health-related benefits or services that may be of interest to You.

F. To Family Members, Relatives or Close Friends.
Unless You object to such disclosure, CHA may disclose Your health information to Your family members, relatives or close personal friends, or any other person identified by You as being involved in Your treatment or payment for Your medical care. If You are not present to agree or object to the CHA's disclosure of Your health information to such person, the CHA may exercise its professional judgment to determine whether the disclosure is in Your best interest. If CHA decides to disclose Your health information to Your family member, relative or other individual You have identified, CHA will only disclose the health information that is relevant to Your treatment or payment.

G. To Business Associates.
CHA may disclose Your health information to its "business associates." Third party administrators, auditors and consultants are examples of some of CHA's business associates.

H. Other Permitted and Required Uses and Disclosures.
In some cases, CHA may use Your health information without obtaining Your authorization and without offering You the opportunity to agree or object as follows:

- as legally required, provided however, that the use or disclosure will be made in compliance with applicable law;
- to a public health authority that is legally authorized to collect or receive such information, or to a foreign government agency that is acting in collaboration with a public health authority;
- to a health oversight agency for oversight activities legally authorized, including audits and inspections, and civil, administrative or criminal investigations, proceedings or actions;
- to a public health authority or to a government authority legally authorized to receive reports of abuse, neglect or domestic violence;
- for judicial or administrative proceedings;
- for law enforcement purposes;
- to a coroner or medical examiner to perform legally authorized duties;
- to funeral directors, consistent with applicable law, as

necessary to carry out their duties;

- to organ procurement organizations or similar entities for the purpose of facilitating organ, eye or tissue donation and transplantation;
- for research purposes;
- to avert a serious threat to health or safety, so long as the disclosure is only to a person who is reasonably able to prevent or lessen such threat;
- for specialized government functions, such as the proper execution of a military mission or national security activities;
- to a correctional institution or law enforcement custodian;
- to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault; and
- to CHA as permitted by law.

YOUR RIGHTS AS A SUBSCRIBER IN THE HEALTH POLICY

As a Subscriber, You have a number of rights associated with Your health information. The following describes Your specific rights.

A. The Right to Request a Restriction or Limit on the Use and Disclosure of Your Health Information.

You have the right to request restrictions or limits on how the Health Policy is allowed to use and/or disclose Your health information. However, CHA does not have to agree to Your requested restriction or limit. If You would like to request a restriction on CHA's use or disclosure of Your health information, please send Your written request to the address listed at the end of this Privacy Notice. Your request must specify: (1) if You would like to restrict or limit Health Policy's use, disclosure or both; (2) what information You would like to restrict or limit; and (3) to whom You want the limit or restriction to apply (e.g., Your spouse).

If CHA agrees to a restriction or limit of Your health information, the restriction or limit will not prevent the Health Policy from disclosing Your health information as follows: (1) to You if You request access to Your health information or if You request an accounting of disclosures; (2) for purposes required or permitted by law (e.g., to comply with laws relating to workers' compensation); or (3) in the case of an emergency, as described below.

If CHA accepts Your restriction or limit regarding how it may use or disclose Your health information, CHA may nevertheless disclose the restricted health information to a health care Provider if You are in need of emergency care and Your restricted health information is needed to provide emergency treatment to You. Before the Health Policy discloses Your restricted health information to a health care Provider during an emergency, CHA will require the health care provider that receives Your health information not to further use or disclose Your health information.

If CHA accepts Your requested restriction or limit, it may terminate the restriction or limit if: (1) You agree to the termination or request the termination in writing; (2) You orally agree to the termination and the oral agreement is appropriately documented; or (3) it informs You that it is terminating the restriction or limit. However, CHA's termination would only be effective for health information it creates or receives after it informs You of the termination.

B. Right to Request Confidential Communications via Alternative Means or Locations.

You have the right to request receipt of health information from CHA by alternative means or via alternative locations provided that You clearly state that the disclosure of all or part of Your health information could endanger You. For example, You may want to receive communications related to Your health care at a different address other than Your home address because You could be in danger of harm if someone at that address saw Your health information. If You wish to receive confidential communications via alternative means or locations, please submit Your written request to the address listed at the end of this Privacy Notice and set forth the alternative means by which You wish to receive communications or the alternative location at which You wish to receive such communications.

C. Right to Inspect and Copy Your Health Information.

You have the right to inspect and obtain a copy of Your health information. However, You are not entitled to access health information that is: (1) contained in psychotherapy notes; (2) compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; or (3) is either subject to the Clinical Laboratory Improvements Amendments of 1988 ("CLIA") to the extent Your access is prohibited by law, or is exempt from CLIA. If You would like to access Your health information, please send Your written request to the address listed at the end of this Privacy Notice. If the Health Policy does not have Your health information in its possession, it will provide You with the appropriate contact information when Your request is received. If You request a copy of Your health information, You will receive a

response to Your request in a timely manner but may be charged a reasonable, cost-based fee to cover copy costs and postage.

In some limited circumstances, CHA may deny Your request for access to health information. For example, CHA may deny access to health information that is subject to the Privacy Act. CHA may also deny You access to health information if such information was obtained from someone other than a health care Provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. If Your request is denied for one of these reasons, You will not have the opportunity to review the denial.

CHA may deny You access to health information if: (1) access is reasonably likely to endanger the life and physical safety of You or someone else; (2) the access requested refers to another person and Your access is reasonably likely to cause substantial harm to such other person; or (3) You are the personal representative of another individual and a health care professional determines that Your access is reasonably likely to cause substantial harm to the individual or another person. If You are denied access for one of these reasons, You are entitled to review by a health care professional that CHA designates , who was not involved in the decision to deny access. If access is ultimately denied, You will be entitled to written explanation of the reasons for the denial.

D. Right to Receive an Accounting of Disclosures.

You have the right to receive an accounting of disclosures of Your health information made by the Health Policy, including CHA's disclosures to or by business associates, for the period of six years prior to the date on which You request an accounting of disclosures, or such lesser period as You indicate. However, You are not entitled to receive an accounting of disclosures that occurred prior to April 14, 2004. If You would like to receive an accounting of disclosures, please send Your written request to the address listed at the end of this Privacy Notice. If CHA does not have Your health information in its possession, it will provide You with the appropriate contact information when it receives Your request. You will receive a response to Your request for an accounting of disclosures no later than sixty days after Your request is received.

Notwithstanding the foregoing, Your accounting of disclosures will not include any disclosures made: (1) to carry out treatment, payment and/or health care operations; (2) directly to You; (3) incident to a use or disclosure otherwise permitted by law; (4) pursuant to Your authorization; (5) to persons involved in Your care; (6) for national security or intelligence purposes as permitted by law; (7) to correctional institutions or law enforcement officials as permitted by law; (8) as part of a limited data set in accordance with law; or (9) that occurred prior to April 14, 2004.

To the extent CHA uses or maintains Electronic Health Records (EHRs), the Health Policy must be able to account for uses and disclosures of that information, even for treatment, payment and/or health care operations purposes. This detail must be retained for a period of at least three years. You have a right to obtain a copy of the record in an electronic format and to direct the Health Policy to transmit a copy of the record to any entity or person You designate. This provision is effective January 1, 2011 or the date EHR is acquired for all EHRs acquired after January 1, 2009. For EHRs acquired on or before January 1, 2009, the provision will be effective January 1, 2014.

You are entitled to one request annually free of charge. Thereafter, the Health Policy CHA may charge You a reasonable, cost-based fee for each subsequent request for an accounting of disclosures within the same twelve-month period. CHA will notify You of the cost for an accounting of disclosures so that You can withdraw or modify Your request before it charges You.

E. Right to Amend Your Health Information.

If You believe CHA has health information about You that is incorrect or incomplete, You may make a written request to the Health Policy stating the reasons to support Your requested amendment. You have the right to request an amendment to Your health information for as long as the Health Policy maintains Your health information. If You would like to amend Your health information, please send Your written request to the address listed at the end of this Privacy Notice. If CHA does not have Your health information in its possession, it will provide You with the appropriate contact information when Your request is received. You will receive a response to Your request for an amendment no later than sixty days after CHA receives Your request. However, the Health Policy may deny Your request for amendment if, for example, CHA determines that it did not create Your health information or Your health information is already accurate and complete. You may respond to CHA's denial by filing a written statement of disagreement, but CHA has the right to rebut Your disagreement. If this occurs, You have the right to request that Your original request, CHA's denial, Your statement of disagreement, and CHA's rebuttal be included in future disclosures of Your health information.

F. Right to Receive a Paper Copy of Your Privacy Notice.
You have the right at any time to obtain a paper copy of this Privacy Notice, even if You receive this Privacy Notice electronically. If You have received an electronic copy of this Privacy Notice, but would like to obtain a paper copy of this Privacy Notice, please send Your written request to the address listed at the end of this Privacy Notice.

MISCELLANEOUS

A. Complaints.
If You believe Your privacy rights have been violated, You may file a complaint through Customer Service by calling the number on the back of the ID card.

You can also file a complaint with the Tennessee Department of Insurance. However such complaints are separate from and in addition to the Appeals processes in this Policy.

If You would like to file a complaint with CHA, please forward Your written complaint to the address listed at the end of this Privacy Notice. If You choose to file a complaint, CHA is prohibited by law from retaliating against You for filing such complaint.

B. Breach.
CHA is required to notify each person whose unsecured protected health information is the subject of a breach, or is reasonably believed to be subject of a breach. Notice must occur within 60 days of discovery of the breach. In addition, CHA must notify the Secretary of the Department of Health and Human Services. If the breach involves 500 or more people, CHA is also required to notify a local media outlet serving the state or jurisdiction in which the people live.

This provision is effective 180 days after the enactment date. The enactment date is February 17, 2009.

C. Effective Date.
This revised notice is effective as of January 1, 2014.

D. Contact Information.
If You need information about this Privacy Notice, please contact, the Privacy Officer, Community Health Alliance
445 South Gay St.
Knoxville, TN 37902.

GENETIC INFORMATION

The Policy operates in compliance with the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233) ("GINA"). GINA prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any person, information about:

- Such person's genetic tests;
- The genetic tests of family members of such person; and
- The manifestation of a disease or disorder in family members of such person.

The term "genetic information" includes participation in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes.

POLICY CHANGES AND TERMINATION

CHA reserves the right to terminate, suspend, withdraw, amend, or modify the Policy, in whole or in part, at any time and for any reason. CHA may also change administrators and service providers, in its sole discretion. CHA does not promise the continuation of any benefit, nor does it promise any specific level of benefits, or cost for such benefits.

No one has the authority to make any oral modifications to this Policy.

GENERAL RESTRICTIONS AGAINST ALIENATION

You may not sell, assign or transfer Your interest in the Policy, except to the extent that CHA permits assignments of Your benefits to health care providers. CHA can, however, disburse funds to Your legally appointed guardian, executor, administrator or personal representative. If You declare bankruptcy or anticipate, sell, transfer, assign or encumber a Policy distribution or payment, voluntarily or involuntarily, Your benefit payments can be restricted.

POLICY ADMINISTRATION AND INTERPRETATION

CHA shall administer this Policy in accordance with its terms and established policies, interpretations, practices, and procedures. CHA shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Policy, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Subscriber's rights, and to decide questions of Policy interpretation and those of fact relating to the Policy.

CLAIMS ADMINISTRATORS

HealthSCOPE Benefits, Inc. will administer and process claims for benefits according to the Policy and consistent with CHA's rules, policies, interpretations, practices and procedures.

NAME OF POLICY

The Community Health Alliance Benefit Policy.

EFFECTIVE DATE OF THIS POLICY

January 1, 2014, except as otherwise noted in this Policy.

NAME, BUSINESS ADDRESS, AND BUSINESS TELEPHONE NUMBER OF INSURER

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

DATE OF THE END OF THE YEAR FOR PURPOSES OF MAINTAINING POLICY'S FISCAL RECORDS

The Policy year shall be a twelve month period ending December 31.

GOVERNING LAW

Your benefits will be governed by the laws of the State of Tennessee., However, if the extraterritorial laws of another state apply to Your benefits, Your benefits will be administered accordingly.

AGENT FOR SERVICE OF LEGAL PROCESS

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Policy for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy including lymphedema.

If You are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Expenses as You determine appropriate care with Your Physician:

- Coverage for Hospitalization following mastectomy for at least 48 hours, unless Your Physician determines early release is appropriate. In the case of early release, at least one home visit will be covered if ordered by Your attending Physician;
- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complication of the mastectomy, including lymphedema.

The amount You must pay for such Covered Expenses, including Policy Year Deductible, are the same as are required for any other Covered Expense. Limits on Benefits are the same as for any other Covered Expense.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health Plans and health insurance issuers generally may not, under Federal or State law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery (not including the day of delivery), or less than 96 hours following a cesarean section (not including the day of surgery). However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, Plans and issuers may not, under Federal law, require that a provider obtain authorization from the Policy or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

KEY TERMS AND DEFINITIONS

The following terms or phrases are used throughout the Policy. These terms or phrases have special meaning.

ADVERSE DETERMINATION

Means a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed; and, based upon the information provided:

- Does not meet the health carrier's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness; or
- Is Experimental or Investigational and involves a condition that is life threatening or seriously disabling.

ALLOWED AMOUNT

Means the maximum amount on which payment is based for covered expenses or covered benefits. If Your Provider charges more than the Allowed Amount, You may have to pay the difference.

APPEAL

Means a request for CHA to review a decision again.

AUTHORIZED REPRESENTATIVE

Means:

- A person to whom a covered person has given express written consent to represent the covered person in an external review;
- A person authorized by law to provide substituted consent for a covered person; or
- A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent.

AUTISM SPECTRUM DISORDERS

Means neurological disorders, usually appearing in the first 3 years of a person's life that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors.

BALANCE BILLING

When a Provider bills You for the difference between the Provider's charge and the Allowed Amount. For example, if the Provider's charge is $100 and the allowed amount is $70, the Provider may bill You for the remaining $30. A Network Provider should not balance bill You for Covered Services. Contact Customer Service if You have questions about how much You may owe.

BIRTHING CENTER

Means an inpatient or outpatient facility which:

- complies with licensing and other legal requirements in the jurisdiction where it is located;
- is engaged mainly in providing a comprehensive Birth Services program to pregnant individuals who are considered normal low risk patients;
- has organized facilities for Birth Services on its premises;
- has Birth Services performed by a Physician specializing in obstetrics and gynecology, or at his or her direction, by a nurse midwife; and
- has 24-hour-a-day Registered Nurse Services.

BIRTH SERVICES

Means antepartum (before labor); intrapartum (during labor); and postpartum (after birth) care. This care is given with respect to: 1) uncomplicated pregnancy and labor; and 2) spontaneous vaginal delivery.

CLINICAL REVIEW CRITERIA

Means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care Subscriber.

COINSURANCE

Means Your share of the costs of a Covered Service, calculated as a percent (for example, 20%) of the Allowed Amount for the service. You pay coinsurance plus any Deductibles You owe. For example, if the Policy's Allowed Amount for an office visit is $100 and You've met Your Deductible, Your coinsurance payment of 20% would be $20. The Policy pays the rest of the Allowed Amount.

COMPLICATIONS OF PREGNANCY

Means a condition due to pregnancy, labor and delivery that requires medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and non-emergency caesarean section aren't complications of pregnancy.

COPAYMENT

Means a fixed amount (for example, $15) You pay for a Covered Service, usually when You receive the

service. The amount can vary by the type of Covered Service.

COVERED EXPENSE OR COVERED BENEFIT OR COVERED SERVICE

Means the expenses as defined and listed on the section entitled, *What's Covered under the Health Coverage Policy*.

COVERED DEPENDENT

Means an Eligible Dependent whose coverage under the Policy: 1) became effective; and 2) has not terminated.

COVERED PERSON

Means a Subscriber and Eligible Dependent whose coverage under the Policy: 1) became effective; and 2) has not terminated.

DEDUCTIBLE

Means the amount You owe for Covered Services before the Policy begins to pay. For example, if Your Deductible is $1,000, the Policy won't pay anything until You've met Your $1,000 Deductible for Covered Services subject to the Deductible. The Deductible may not apply to all Subscriber.

DRUG

Means a substance recognized by an official pharmacopoeia or formulary; a substance intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease; a substance (other than food) intended to affect the structure or any function of the body; a substance intended for use as a component of a medicine but not a device or component, part or accessory of a device; biological products are included within this definition and are generally covered by the same laws and regulations, but differences exist regarding their manufacturing processes (chemical process versus biological process.

DURABLE MEDICAL EQUIPMENT

Means equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for Durable Medical Equipment may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

ELIGIBLE DEPENDENT

Means a Dependent who meets the eligibility requirements under the Policy. Refer to the *Dependent Eligibility* section on page 3 under *Eligibility and Enrollment* for the specific definition.

ELIGIBLE INDIVIDUAL

Means an individual who meets the eligibility requirements under the Policy. Refer to the *Eligibility* section for the specific definition.

EMERGENCY CARE

Means medical and health Subscriber provided for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health or survival of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

EMERGENCY MEDICAL CONDITION

Means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in:

- placing the health or survival of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

EMERGENCY MEDICAL TRANSPORTATION

Means ambulance Subscriber for an Emergency Medical Condition.

EMERGENCY ROOM CARE

Means Emergency Services You get in an Emergency Room.

EMERGENCY SERVICES

Means evaluation of an Emergency Medical Condition and treatment to keep the condition from getting worse.

ESSENTIAL HEALTH BENEFITS

Means, under section 1302(b) of the Patient Protection and Affordable Care Act, as amended from this time to time, those health benefits to include at least the following general categories and the items and Subscriber covered within the categories: ambulatory patient Subscriber; emergency Subscriber; hospitalization; maternity and newborn care; mental health and substance abuse disorder Subscriber, including behavioral health treatment; prescription drugs; rehabilitative and habilitative Subscriber and devices; laboratory Subscriber; preventive and wellness Subscriber and chronic disease management; and pediatric

Subscriber, including oral and vision care.

EXCLUDED SERVICES

Means health care Subscriber the Policy doesn't pay for or cover.

EXPERIMENTAL / INVESTIGATIONAL SERVICES

Means at the time a determination is made regarding coverage in a particular case, a drug, device, diagnostic or screening procedure, or a medical treatment or procedure will be determined to be "investigative" if reliable, authoritative evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes as compared with the standard means of treatment or diagnosis.

CHA will base its determination upon an examination of one or more of the following kinds of reliable evidence, none of which shall be determinative in and of itself:

- Published reports, articles, or consensus expert panel opinions and recommendations in the authoritative peer reviewed medical and scientific literature
- Written protocol(s) used by the treating Provider; or the protocol(s) of another Provider studying substantially the same service; or the written informed consent used by the treating Provider or by another Provider studying substantially the same service
- Review by a financially disinterested, external, specialty appropriate board-certified expert medical reviewer

All determinations of reliable evidence shall be made by CHA.

Notwithstanding the above, a drug, device, diagnostic or screening procedure, or a medical treatment or procedure will not be determined to be "investigative" and will be considered a covered benefit when it is being administered or performed as part of a Phase III clinical investigational trial where all treatment arms involve covered Subscriber for covered conditions. In addition, in the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where: (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and Biologics Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or Clinical Pharmacology, United States Pharmacopoeia Drug Information, American Medical Association Drug Evaluations, American Hospital Formulary Service Drug Information, or two articles from major peer reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; or (2) the drug is provided in association with a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute ("NCI") or (3) the drug is provided in association with a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by CHA.

FACILITY

Means an institution providing health care Subscriber or a health care setting including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

FINAL ADVERSE DETERMINATION

Means an adverse determination involving a covered benefit that has been upheld at the completion of the internal appeal process.

GRIEVANCE

A complaint that You communicate to CHA.

HABILITATION SERVICES

Means health care Subscriber that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These Subscriber may include physical and occupational therapy, speech-language pathology and other Subscriber for people with disabilities in a variety of inpatient and/or outpatient settings.

HEALTH INSURANCE

Means a contract that requires Your health insurer to pay some or all of Your health care costs in exchange for a Premium.

HEALTH INSURANCE COVERAGE

Means benefits consisting of medical care provided directly, through insurance or

reimbursement, or otherwise and including items and Subscriber paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

- Coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Credit only insurance;
- Coverage for on-site medical clinics;
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
- If offered separately: limited scope dental or vision benefits, benefits for long term care, nursing home care, home health care, community based care, or any combination of these, or other similar, limited benefits as are specified in regulations;
- If offered as independent, noncoordinated benefits;
- Coverage only for a specified disease or illness;
- Hospital indemnity or other fixed indemnity insurance;
  If offered as a separate insurance policy: Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code, and similar supplemental coverage under a group health plan.

HOME HEALTH CARE

Means health care Subscriber a person receives at home.

HOME HEALTH CARE AGENCY

Means a public or private agency that provides skilled nursing functions or activities in the Covered Person's home. It is licensed as such (or if no license is required, approved as such) by a state department or agency having authority over home health agencies.

HOSPITAL

Means an institution which:

- is legally operated in the jurisdiction where it is located;
- is engaged mainly in providing inpatient medical care and treatment for Injury and Illness/Sickness in return for compensation;
- has organized facilities for diagnosis and major surgery on its premises;
- is supervised by a staff of at least two Physicians;
- has 24-hour-a-day nursing service by Registered Nurses; and
- is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or Skilled Nursing Facility or similar institution; or a Long Term Acute Care Facility (LTAC).

HOSPICE SERVICES

Means Subscriber to provide comfort and support for persons in the last stages of a terminal illness and their families.

HOSPITALIZATION

Means care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

HOSPITAL OUTPATIENT CARE

Means care in a Hospital that doesn't require an overnight stay.

ILLNESS

Means a sickness or a disease of a Subscriber or Covered Dependent. Illness will include congenital defects or birth abnormalities.

INDEPENDENT REVIEW ORGANIZATION

Means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

IN-NETWORK COINSURANCE

Means the percent (for example, 20%) You pay of the Allowed Amount for Covered Services to Providers who contract with Your Insurer.

IN-NETWORK COPAYMENT

Means a fixed amount (for example, $15) You pay for Covered Services to Providers who contract with Your Insurer.

INJURY

Means accidental bodily injury of a Subscriber or Covered Dependent.

INTENSIVE CARE UNIT

Means a section, ward or wing within the Hospital which:

- is separated from other Hospital facilities;

- is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;
- has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
- provides room and board; and
- provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.

LICENSED PRACTICAL NURSE

Means an individual who has received: 1) specialized nursing training; and 2) practical nursing experience. He or she is licensed to perform nursing service by the state in which he or she performs such service. This definition will include licensed vocational nurses with the above qualifications.

LIFE THREATENING CONDITION OR DISEASE

Means a condition or disease which, according to the current diagnosis by the covered person's treating physician, has a high probability of causing the covered person's death.

MAXIMUM OUT OF POCKET (MOOP)

Means the most You pay during a policy period (usually a year) before the Policy begins to pay 100% of the Allowed Amount. This limit never includes Your premiums, balance-billed charges or health care Your Policy doesn't cover.

MEDICAL AND SCIENTIFIC EVIDENCE

Means:

- peer reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meets the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and Medlars database Health Services Technology Assessment Research;
- medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act;
- these standard reference compendia: the American Hospital Formulary Service Drug Information, the American Medical Association Drug Evaluation the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia Drug Information;
- findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health Subscriber.

MEDICALLY NECESSARY

Means health care Subscriber or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms that meet accepted standards of medicine.

NETWORK

Means the facilities, providers and suppliers Your Insurer has contracted with to provide health care Subscriber.

NETWORK PROVIDER

Means a participating Provider that the PPO network or one of its rental networks have contracted with or made arrangements with to provide health Subscriber to Covered Persons. A Network Provider has agreed to charge Subscribers a discounted rate. To determine if a Provider is a Network Provider log onto www.chatn.org and click the *Find a Provider* tab. You may also call the number on Your ID card and Customer Service can locate a Network Provider for You. A provider list based on Your zip code will be sent to You, free of charge, upon Your request.

The term Provider means a Physician, eligible professional provider, Hospital and eligible health care facility provider.

OUT-OF-NETWORK PROVIDER

An Out-of-Network Provider is a Provider not under contract as a Network Provider either with the Covered Person's PPO network or a reciprocal network. No benefits or payments are available for Subscriber received from and Out of Network Provider, even if the Subscriber would otherwise be deemed Covered Services, except in the case of a true Emergency.

PHYSICIAN

Means a person who has successfully completed the prescribed course of studies in medicine in a medical school officially recognized and who has acquired the requisite qualifications for license in the state in which the treatment is received in the practice of medicine. He or she must be practicing within the scope of that license.

PHYSICIAN SERVICES

Means health care Subscriber a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

POLICY

Means benefits provided to You to pay for Your health care Subscriber.

POLICY YEAR

Means a 12-month period of time that follows the Policy's Effective Date and each subsequent twelve-month period this Policy remains in force.

PRACTITIONER

A professional who provides health care Subscriber. Practitioners are usually licensed as required by law.

PREAUTHORIZATION

Means a decision by Your Insurer that a health care service, treatment plan, prescription drug, or durable medical equipment is Medically Necessary. Sometimes called prior authorization, prior approval or precertification. Your Insurer may require preauthorization for certain Subscriber before You receive them, except in an emergency. Preauthorization isn't a promise Your Policy will cover the cost.

PREFERRED PROVIDER

Means a Provider who has a contract with Your Insurer to provide Subscriber to You at a discount. Check the Policy to see if You can see all Preferred Providers or if Your Policy has a "tiered" network and You must pay extra to see some providers. Your Policy may have Preferred Providers who are also "participating" Providers. Participating Providers also contract with Your Insurer, but the discount may not be as great, and You may have to pay more.

PREMIUM

Means the amount that must be paid for Your Policy. You usually pay it monthly, quarterly or yearly.

PRESCRIPTION DRUG

Means a drug that can be dispensed to the public only with an order given by a properly authorized person. The designation of a medication as a prescription drug is made by the U.S. Food and Drug Administration.

PRESCRIPTION DRUG COVERAGE

Means Health Insurance or Plan that helps pay for prescription drugs and medications.

PRESCRIPTION DRUG PRODUCT

A prescription drug product requires a doctor's authorization to purchase,

PRIMARY CARE PHYSICIAN

Means a Physician, including a Pediatrician and OB/GYN (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care Subscriber for a patient.

PRIMARY CARE PROVIDERS

Means a Physician, including a Pediatrician and OB/GYN(M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care Subscriber.

PROVIDER

Means a Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

RECONSTRUCTIVE SURGERY

Means surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

REGISTERED NURSE

Means a professional nurse who has the right to use the title Registered Nurse (R.N.) in the state in which Subscriber are provided.

REHABILITATION SERVICES

Means health care Subscriber that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These Subscriber may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation Subscriber in a variety of inpatient and/or outpatient settings.

REIMBURSABLE PAYMENTS

Means payments made by this Policy for health care benefits that are or become the responsibility of another party under the subrogation provisions as described in this Policy.

SERIOUS MEDICAL CONDITION

Means a health condition of illness that requires immediate medical attention where failure to provide immediate medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

SERIOUSLY DISABLING

Means a health condition or illness that involves a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

SKILLED NURSING CARE

Means Subscriber from licensed nurses in Your own home or in a nursing home. Skilled care Subscriber are from technicians and therapists in Your home or in a nursing home.

SPECIALIST

Means a physician specialist that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician Specialist is a Provider who has more training in a specific area of health care.

SUBSCRIBER

Means an individual who meets all applicable eligibility requirements, has enrolled for coverage and for whom CHA has received the applicable Premium for coverage.

SUBSCRIBER, YOU, YOUR

Means any person enrolled as a Subscriber or Covered Dependent

URGENT CARE CENTER

Means a facility operated to provide health care Subscriber in emergencies or after hours. It is not part of a Hospital.

USUAL AND CUSTOMARY

Means the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The Usual and Customary amount as determined at the sole discretion of the Health Policy sometimes is used to determine the Allowed Amount.

URGENT CARE

Means care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. CHA reserves the right to make changes to the Policy. Generally, Policy changes are announced each year in the fall during Annual Enrollment. To receive benefits under the Policy, You must see a Network Provider. If You see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	
Family	
Policy Year Out-of-Pocket Maximum (Excludes Deductible)	
Individual	
Family	
Maximum Benefit Limit Per Covered Individual for:	
Transplants	

	In-Network
Accidental Dental Care	
Acupuncture	
Ambulance	
Asthma	
Chiropractic Care	
Contraceptive Services	
CT, MRI and PET scan	
Durable Medical Equipment	
Emergency Room	
Home Healthcare	
Home Infusion Therapy	
Hospice Care	
Infertility	
Inpatient Hospital Care	
Inpatient Rehabilitations	
Lab and X-Ray	
Maternity Care	
Medical Supplies	
Mental Health Inpatient & Outpatient Services	
Nutritionist	
Occupational Therapy	
Office Visits	
Oral Surgery	
Outpatient Hospital Care	
Physical Therapy	
Physician Services	
Preventive Care Services	

Prescription Drugs	
Retail	
Mail Order or from a retail pharmacy	
Radiation Therapy Chemotherapy	
Skilled Nursing Facility	
Speech Therapy	
Substance Abuse Inpatient & Outpatient Care	
TMJ	
Transplants	
Urgent Care	
All Other Covered Expenses	

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$4,000
Family	$8,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,350
Family	$12,700
Coinsurance	40% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$30 Copay
Specialist Office Visit	40% Coinsurance after Deductible
Other Practitioner	40% Coinsurance after Deductible
Prenatal and Postnatal Care	40% Coinsurance after Deductible
Family Planning and Reproductive Services	40% Coinsurance after Deductible
Chiropractic Care	$30 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	40% Coinsurance after Deductible
Office Laboratory	40% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	40% Coinsurance after Deductible
Diabetic Care Management	40% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	40% Coinsurance after Deductible
Dental Anesthesia	40% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	40% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	40% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	40% Coinsurance after Deductible
Hospice Services	40% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	40% Coinsurance after Deductible
Inpatient Physician and Surgical Services	40% Coinsurance after Deductible

Skilled Nursing Facility	40% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	40% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	40% Coinsurance after Deductible
Urgent Care Centers or Facilities	40% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	40% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	40% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	40% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	40% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	40% Coinsurance after Deductible
Reconstructive Surgery	40% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	40% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	40% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	40% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	40% Coinsurance after Deductible
Home Health Care Services	40% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	40% Coinsurance after Deductible
Durable Medical Equipment	40% Coinsurance after Deductible
Hearing Aids	40% Coinsurance after Deductible

Rehabilitative Speech Therapy	40% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	40% Coinsurance after Deductible
Clinical Trials	40% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 40% Coinsurance after Deductible
	Preferred Brand Drugs 40% Coinsurance after Deductible
	Non-Preferred Brand Drugs 40% Coinsurance after Deductible
	Specialty Drugs – 40% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 40% Coinsurance after Deductible
	Preferred Brand Drugs - 40% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 40% Coinsurance after Deductible
	Specialty Drugs – 40% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	40% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	40% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	40% Coinsurance after Deductible
Transplants	40% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$6,250
Family	$12,500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,250
Family	$12,500
Coinsurance	0% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible
Prenatal and Postnatal Care	0% Coinsurance after Deductible
Family Planning and Reproductive Services	0% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible
Office Laboratory	0% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	0% Coinsurance after Deductible
Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	0% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	0% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance after Deductible

Skilled Nursing Facility	0% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	0% Coinsurance after Deductible
Urgent Care Centers or Facilities	0% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	0% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	0% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	0% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	0% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible

Rehabilitative Speech Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	0% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 0% Coinsurance after Deductible
	Preferred Brand Drugs 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible
	Preferred Brand Drugs - 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	0% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	0% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible
	Pre-certification required

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	In-Network
Deductibles	
Individual	$6,350
Family	$12,700
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,350
Family	$12,700
Coinsurance	0% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible
Prenatal and Postnatal Care	0% Coinsurance after Deductible
Family Planning and Reproductive Services	0% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible
Office Laboratory	0% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible
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Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information
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Services Received at a Facility	
Outpatient Facility Fee	0% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance after Deductible

Skilled Nursing Facility	0% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
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Urgent Care Centers or Facilities	0% Coinsurance after Deductible
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Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	0% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	0% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible

Rehabilitative Speech Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	0% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 0% Coinsurance after Deductible
	Preferred Brand Drugs 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
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	Preferred Brand Drugs - 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	0% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	0% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible
	Pre-certification required

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	In-Network
Deductibles	
Individual	$500
Family	$1,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$4,500
Family	$9,000
Coinsurance	20% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$20 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$20 Copay
Prenatal and Postnatal Care	$20 Copay
Family Planning and Reproductive Services	20% Coinsurance after Deductible
Chiropractic Care	$20 Copay
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	20% Coinsurance after Deductible
Diabetic Care Management	20% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	20% Coinsurance after Deductible
Dental Anesthesia	20% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible

Skilled Nursing Facility	20% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	20% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	20% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	20% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	20% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Deductible
Reconstructive Surgery	20% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	20% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	20% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	20% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	20% Coinsurance after Deductible
Home Health Care Services	20% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Hearing Aids	20% Coinsurance after Deductible

Rehabilitative Speech Therapy	20% Coinsurance Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% Coinsurance Limit of 20 Visits per Calendar Year
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible
Prosthetic Devices	20% Coinsurance after Deductible
Clinical Trials	20% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $30 Copay
	Non-Preferred Brand Drugs - $60 Copay
	Specialty Drugs – 20% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $90 Copay, Retail; $60 Copay, Mail Order
	Non-Preferred Brand Drugs - $180 Copay, Retail; $120, Mail Order
	Specialty Drugs – 20% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	20% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	20% Coinsurance after Deductible
Transplants	20% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$ 1,000
Family	$2,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$4,000
Family	$8,000
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$20 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$20 Copay
Prenatal and Postnatal Care	$20 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$20 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	30% Coinsurance after Deductible
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	30% Coinsurance Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	30% Coinsurance Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $30 Copay
	Non-Preferred Brand Drugs - $60 Copay
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $90 Copay, Retail; $60 Copay, Mail Order
	Non-Preferred Brand Drugs - $180 Copay, Retail; $120, Mail Order
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$ 2,000
Family	$4,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,350
Family	$12,700
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$25 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$25 Copay
Prenatal and Postnatal Care	$25 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$25 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	0% Coinsurance
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $40 Copay
	Non-Preferred Brand Drugs - $75 Copay
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $120 Copay, Retail; $80 Copay, Mail Order
	Non-Preferred Brand Drugs - $225 Copay, Retail; $150, Mail Order
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$2,000
Family	$4,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$5,200
Family	$10,400
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$20 Copay
Specialist Office Visit	$45 Copay
Other Practitioner	$20 Copay
Prenatal and Postnatal Care	$20 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$20 Copay
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	0% Coinsurance
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$45 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	$45 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$45 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $35 Copay
	Non-Preferred Brand Drugs - $60 Copay
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $105 Copay, Retail; $70 Copay, Mail Order
	Non-Preferred Brand Drugs - $180 Copay, Retail; $120, Mail Order
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

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	In-Network
Deductibles	
Individual	$250
Family	$500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$2,250
Family	$4,500
Coinsurance	20% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$10 Copay
Specialist Office Visit	$25 Copay
Other Practitioner	$10 Copay
Prenatal and Postnatal Care	$10 Copay
Family Planning and Reproductive Services	20% Coinsurance after Deductible
Chiropractic Care	$10 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	$0 Copay
Treatment for Temporomandibular Joint Disorders	20% Coinsurance after Deductible
Diabetic Care Management	20% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	20% Coinsurance after Deductible
Dental Anesthesia	20% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$25 Copay
Services Received at a Facility	
Outpatient Facility Fee	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible

Skilled Nursing Facility	20% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	20% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	20% Coinsurance after Deductible
Urgent Care Centers or Facilities	$25 Copay
Delivery and All Inpatient Services for Maternity Care	20% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	20% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Deductible
Reconstructive Surgery	20% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	20% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	$50 Copay
Laboratory Outpatient and Professional Services	$50 Copay
Other Services	
Emergency Transport/Ambulance	20% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	20% Coinsurance after Deductible
Home Health Care Services	20% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible

Hearing Aids	20% Coinsurance after Deductible
Rehabilitative Speech Therapy	$25 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$25 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	20% Coinsurance after Deductible
Clinical Trials	20% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $25 Copay
	Non-Preferred Brand Drugs - $50 Copay
	Specialty Drugs – 20% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $75 Copay, Retail; $50 Copay, Mail Order
	Non-Preferred Brand Drugs - $150 Copay, Retail; $100, Mail Order
	Specialty Drugs – 20% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	20% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	20% Coinsurance after Deductible
Transplants	20% Coinsurance after Deductible
	Pre-certification required

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	In-Network
Deductibles	
Individual	$75
Family	$150
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$1,000
Family	$2,000
Coinsurance	10% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$5 Copay
Specialist Office Visit	$10 Copay
Other Practitioner	$5 Copay
Prenatal and Postnatal Care	$5 Copay
Family Planning and Reproductive Services	10% Coinsurance after Deductible
Chiropractic Care	$5 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	10% Coinsurance after Deductible
Diabetic Care Management	10% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	10% Coinsurance after Deductible
Dental Anesthesia	10% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$10 Copay
Services Received at a Facility	
Outpatient Facility Fee	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance
Hospice Services	10% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance

Skilled Nursing Facility	10% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	10% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	10% Coinsurance after Deductible
Urgent Care Centers or Facilities	$10 Copay
Delivery and All Inpatient Services for Maternity Care	10% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	10% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	10% Coinsurance after Deductible
Reconstructive Surgery	10% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	10% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	$25 Copay
Laboratory Outpatient and Professional Services	$25 Copay
Other Services	
Emergency Transport/Ambulance	10% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	10% Coinsurance after Deductible
Home Health Care Services	10% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Hearing Aids	10% Coinsurance after Deductible

Rehabilitative Speech Therapy	$10 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$10 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	10% Coinsurance after Deductible
Clinical Trials	10% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $4 Copay
	Preferred Brand Drugs - $15 Copay
	Non-Preferred Brand Drugs - $35 Copay
	Specialty Drugs – 10% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $12 Copay, Retail; $8 Copay, Mail Order
	Preferred Brand Drugs - $45 Copay, Retail; $30 Copay, Mail Order
	Non-Preferred Brand Drugs - $105 Copay, Retail; $70, Mail Order
	Specialty Drugs – 10% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	10% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	10% Coinsurance after Deductible
Transplants	10% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$3,500
Family	$7,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,350
Family	$12,700
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$25 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$25 Copay
Prenatal and Postnatal Care	$25 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$25 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	0% Coinsurance
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $40 Copay
	Non-Preferred Brand Drugs - $75 Copay
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $120 Copay, Retail; $80 Copay, Mail Order
	Non-Preferred Brand Drugs - $225 Copay, Retail; $150, Mail Order
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$2,750
Family	$5,500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$5,200
Family	$10,400
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$20 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$20 Copay
Prenatal and Postnatal Care	$20 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$20 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	30% Coinsurance after Deductible
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $35 Copay
	Non-Preferred Brand Drugs - $60 Copay
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $105 Copay, Retail; $70 Copay, Mail Order
	Non-Preferred Brand Drugs - $180 Copay, Retail; $120, Mail Order
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

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	In-Network
Deductibles	
Individual	$450
Family	$900
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$2,250
Family	$4,500
Coinsurance	20% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$10 Copay
Specialist Office Visit	$30 Copay
Other Practitioner	$10 Copay
Prenatal and Postnatal Care	$10 Copay
Family Planning and Reproductive Services	20% Coinsurance after Deductible
Chiropractic Care	$10 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	20% Coinsurance after Deductible
Diabetic Care Management	20% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	20% Coinsurance after Deductible
Dental Anesthesia	20% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$30 Copay
Services Received at a Facility	
Outpatient Facility Fee	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible

Skilled Nursing Facility	20% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	20% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	20% Coinsurance after Deductible
Urgent Care Centers or Facilities	$30 Copay
Delivery and All Inpatient Services for Maternity Care	20% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	20% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Deductible
Reconstructive Surgery	20% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	20% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	$50 Copay
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	20% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	20% Coinsurance after Deductible
Home Health Care Services	20% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Hearing Aids	20% Coinsurance after Deductible

Rehabilitative Speech Therapy	$30 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$30 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	20% Coinsurance after Deductible
Clinical Trials	20% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $25 Copay
	Non-Preferred Brand Drugs - $50 Copay
	Specialty Drugs – 20% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $75 Copay, Retail; $50 Copay, Mail Order
	Non-Preferred Brand Drugs - $150 Copay, Retail; $100, Mail Order
	Specialty Drugs – 20% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	20% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	20% Coinsurance after Deductible
Transplants	20% Coinsurance after Deductible
	Pre-certification required

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	In-Network
Deductibles	
Individual	$150
Family	$300
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$1,000
Family	$2,000
Coinsurance	10% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$5 Copay
Specialist Office Visit	$15 Copay
Other Practitioner	$5 Copay
Prenatal and Postnatal Care	$5 Copay
Family Planning and Reproductive Services	10% Coinsurance after Deductible
Chiropractic Care	$5 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	10% Coinsurance after Deductible
Diabetic Care Management	10% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	10% Coinsurance after Deductible
Dental Anesthesia	10% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$15 Copay
Services Received at a Facility	
Outpatient Facility Fee	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible

Skilled Nursing Facility	10% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	10% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	10% Coinsurance after Deductible
Urgent Care Centers or Facilities	$15 Copay
Delivery and All Inpatient Services for Maternity Care	10% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	10% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	10% Coinsurance after Deductible
Reconstructive Surgery	10% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	10% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	$50 Copay
Laboratory Outpatient and Professional Services	0% Coinsurance
Other Services	
Emergency Transport/Ambulance	10% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	10% Coinsurance after Deductible
Home Health Care Services	10% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Hearing Aids	10% Coinsurance after Deductible

Rehabilitative Speech Therapy	$15 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$15 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	10% Coinsurance after Deductible
Clinical Trials	10% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $4 Copay
	Preferred Brand Drugs - $15 Copay
	Non-Preferred Brand Drugs - $35 Copay
	Specialty Drugs – 10% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $12 Copay, Retail; $8 Copay, Mail Order
	Preferred Brand Drugs - $45 Copay, Retail; $30 Copay, Mail Order
	Non-Preferred Brand Drugs - $105 Copay, Retail; $70, Mail Order
	Specialty Drugs – 10% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	10% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	10% Coinsurance after Deductible
Transplants	10% Coinsurance after Deductible
	Pre-certification required

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	In-Network
Deductibles	
Individual	$3,500
Family	$7,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$3,500
Family	$7,000
Coinsurance	0% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible
Prenatal and Postnatal Care	0% Coinsurance after Deductible
Family Planning and Reproductive Services	0% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible
Office Laboratory	0% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	0% Coinsurance after Deductible
Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	0% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	0% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance after Deductible

Skilled Nursing Facility	0% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	0% Coinsurance after Deductible
Urgent Care Centers or Facilities	0% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	0% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	0% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	0% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	0% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible

Rehabilitative Speech Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	0% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 0% Coinsurance after Deductible
	Preferred Brand Drugs 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible
	Preferred Brand Drugs - 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	0% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	0% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible
	Pre-certification required

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	In-Network
Deductibles	
Individual	$2,750
Family	$5,500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$2,750
Family	$5,500
Coinsurance	0% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible
Prenatal and Postnatal Care	0% Coinsurance after Deductible
Family Planning and Reproductive Services	0% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible
Office Laboratory	0% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	0% Coinsurance after Deductible
Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	0% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	0% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance after Deductible

Skilled Nursing Facility	0% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	0% Coinsurance after Deductible
Urgent Care Centers or Facilities	0% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	0% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	0% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	0% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	0% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible

Rehabilitative Speech Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	0% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 0% Coinsurance after Deductible
	Preferred Brand Drugs 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible
	Preferred Brand Drugs - 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	0% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	0% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$1,000
Family	$2,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$1,000
Family	$2,000
Coinsurance	0% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
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Family Planning and Reproductive Services	0% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible
Office Laboratory	0% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	0% Coinsurance after Deductible
Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	0% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	0% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance after Deductible

Skilled Nursing Facility	0% Coinsurance after Deductible Limit of 60 Days per Benefit Period
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Habilitation Services	0% Coinsurance after Deductible
Urgent Care Centers or Facilities	0% Coinsurance after Deductible
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Mental/Behavioral Health Outpatient Services	0% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	0% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	0% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible

Rehabilitative Speech Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	0% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 0% Coinsurance after Deductible
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	Note: Certain drugs require limitations. See the Formulary for details.
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Transplants	0% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$250
Family	$500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$500
Family	$1,000
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
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Well Woman Exam	$0 Copay
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	Non-Preferred Brand Drugs - 30% Coinsurance after Deductible
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	Note: Certain drugs have limitations. See the Formulary for details.
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Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

SERFF Tracking #:	*CHAM-129074749*	***State Tracking #:***	*H-130572*	***Company Tracking #:***

State:	*Tennessee*	***Filing Company:***	*Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CHA Individual*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type: Neutral

Overall Percentage of Last Rate Revision: %

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Community Health Alliance Mutual Insurance Company	New Product	%	%				%	%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								
Policy Holders:								

State: *Tennessee* ***Filing Company:*** *Community Health Alliance Mutual Insurance Company*

TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*

Product Name: *CHA Individual*

Project Name/Number: */*

Rate Review Detail

COMPANY:

Company Name: Community Health Alliance Mutual Insurance Company

HHS Issuer Id: 66842

Product Names: Individual

Trend Factors:

FORMS:

New Policy Forms: PTN_100_14

Affected Forms:

Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual

Member Months: 0

Benefit Change: Increase

Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

Total Earned Premium:

Total Incurred Claims:

Annual $: Min: Max: Avg:

REQUESTED RATE:

Projected Earned Premium: 0.00

Projected Incurred Claims: 0.00

Annual $: Min: 0.00 Max: 0.00 Avg: 0.00

SERFF Tracking #:	*CHAM-129074749*	***State Tracking #:***	*H-130572*	***Company Tracking #:***

State:	*Tennessee*	***Filing Company:***	*Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CHA Individual*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		CHA Individual On Exchange Rates	PTN_100_14	New		CHA Individual_OnExchange_SERFF Format.xls,

SERFF Tracking #:	*CHAM-129074749*	***State Tracking #:***	*H-130572*	***Company Tracking #:***

State:	*Tennessee*	***Filing Company:***	*Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CHA Individual*		
Project Name/Number:	*/*		

Attachment CHA Individual_OnExchange_SERFF Format.xls is not a PDF document and cannot be reproduced here.

Supporting Document Schedules

Bypassed - Item:	Accident & Health - Individual New Rates
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum A & H Certification - Individual
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Cover Letter Accident & Health
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Description of Variables
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Filing Fees
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	PPACA Uniform Compliance Summary

SERFF Tracking #:	*CHAM-129074749*	***State Tracking #:***	*H-130572*	***Company Tracking #:***	

State:	*Tennessee*	***Filing Company:***	*Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CHA Individual*		
Project Name/Number:	*/*		

Comments:	
Attachment(s):	Individual Compliance Summary.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Third Party Authorization
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Readibility Certification.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	Part III Memorandum CHA Individual 042613.pdf CHA Individual - 2014 Actuarial Memorandum revised 05062013.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	URRT_CHA_Ind_2013042991736.xml

SERFF Tracking #:	*CHAM-129074749*	***State Tracking #:***	*H-130572*	***Company Tracking #:***

State:	*Tennessee*	***Filing Company:***	*Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*CHA Individual*		
Project Name/Number:	*/*		

Item Status:	
Status Date:	

Satisfied - Item:	Modified Plan and Benefits
Comments:	Removed Modified as it only applies to off exchange.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Policy Form Id Crosswalk
Comments:	
Attachment(s):	CHA PolicyFormId Crosswalk.xlsx
Item Status:	
Status Date:	

State: Tennessee **Filing Company:** Community Health Alliance Mutual Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: CHA Individual
Project Name/Number: /

Attachment URRT_CHA_Ind_2013042991736.xml is not a PDF document and cannot be reproduced here.

Attachment CHA PolicyFormId Crosswalk.xlsx is not a PDF document and cannot be reproduced here.

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☑ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Community Health Alliance			PTN_100_14	☐ Yes ☐ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Non discrimination provision			
	Page Number: 3			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: No dollar limits on essential benefits			
	Page Number: Schedule of Benefits - Exhibit A			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: No lifetime dollar limits on essential benefits			
	Page Number: Schedule of Benefits - Exhibit A			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain
	Explanation: no rescission listed as reason for coverage to end. references fraud and intentional misrepresentation			
	Page Number: 4			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Preventative covered at 100%			
	Page Number: pp 10-12			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Coverage extended to age 26			
	Page Number: 3			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Contains required appeals and review processes 28-29			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no,** please explain.
	Explanation: no pre-auth required- claim paid even if OON			
	Page Number: 6			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Primary care physician definition includes pediatricians			
	Page Number: 44			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Primary care physician definition includes ob/gyns			
	Page Number: 44			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

TENNESSEE

READIBILITY CERTIFICATE

COMPANY NAME: COMMUNITY HEALTH ALLIANCE MUTUAL INSURANCE COMPANY

As an Officer of Community Health Alliance Mutual Insurance Company, I hereby certify that the following forms achieve a Flesch score that meets or exceeds the requirements. Each form was scored in accordance with T.C.A. Sec. 56-7-1605.

Form Number	Flesch Score
ENT_100_EPO_14	40.5
ENT_100_POS_14	40.0
PTN_100_14	42.5

Judy Slagle, SVP and Chief Operating Officer

6/13/13
Date

ACTUARIAL MEMORANDUM

Community Health Alliance Mutual Insurance Company
Rates for Individual Policies
Effective January 1, 2014

GENERAL INFORMATION

Company Legal Name: Community Health Alliance Mutual Insurance Company
State: Tennessee
HIOS Issuer ID: 66842
Market: Individual
Effective Date: January 1, 2014

Contact Information:

Name: Brian L. Klapman
Primary Phone: (865) 310-7515
Primary E-mail: bklapman@chatn.org

INTRODUCTION

The purpose of this actuarial memorandum is to provide initial rates and supporting documentation for Community Health Alliance's (CHA) individual products.

CHA has engaged OptumInsight (Optum) to develop the premium rates for its new Individual health policies, to test these rates for the expected medical loss ratios (MLR), and to file them with the Tennessee Insurance Division with an effective date of January 1, 2014. This will be CHA's first offering of individual plans.

PROPOSED RATE INCREASES

These plans, along with the small group plans filed under separate cover, represent CHA's entrance into the Tennessee market. As such, they have no experience or current rates so proposed rate increases are not applicable.

EXPERIENCE PERIOD PREMIUM AND CLAIMS

As described above, CHA has no premium or claim experience. The rates were developed using external data sources. These sources and the adjustments made to them are discussed below.

BENEFIT CATEGORIES

As described above, we do not have claim experience. However, our rating model (discussed in greater detail below) has claims separated into the various components as follows. Note that these are basically consistent with the methods used in the URRT:

1. ***Inpatient Hospital*:** Includes facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

2. ***Outpatient Hospital*:** Includes non-capitated facility services for surgery, emergency room, urgent care, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.

3. ***Professional*:** Includes non-capitated primary care, specialist, therapy, the professional component of laboratory/radiology and surgery, and other professional services, other than hospital based professionals whose payments are included in facility fees.

4. ***Other Medical*:** Includes non-capitated ambulance, home health care, chiropractic, DME, prosthetics, supplies, vision exams, dental services, hearing aids, and other services.

5. ***Capitation*:** CHA does not anticipate having any capitated contracts in 2014

6. ***Prescription Drug*:** Includes drugs dispensed by a pharmacy. This amount should be net of rebates received from drug manufacturers.

PROJECTION FACTORS

Because we did not have experience to project, this is not applicable. The application of some of these adjustments to the manual pricing model is discussed in following sections.

CREDIBILITY MANUAL RATE DEVELOPMENT

Because we did not have experience to project, this is not applicable. The application of some of these adjustments to the manual pricing model is discussed in following sections.

1. SOURCE AND APPROPRIATENESS OF EXPERIENCE DATA USED

We used the Optum Comprehensive Pricing model to develop PMPM claims for an average 12 month policy period beginning 1/1/2014. The model has age, gender, and area claims relativities that allow it to calculate the PMPM claims separately for male and female members by age bracket, in different metropolitan statistical areas (MSAs) or in the non-MSA parts of states.

The data underlying the cost model come from the experience of commercial carriers during 2010-2011. There are 114 million member-months of exposures, primarily from large groups, with the rest from small groups and individuals. As such, the underlying data represent fairly closely the claims from an average commercially-insured, primarily non-underwritten population by age bracket and gender.

2. ADJUSTMENTS MADE TO THE DATA

1. **Utilization:** The Optum model and underlying utilization are primarily based on large group experience. Adjustments were made to capture key underwriting differences between large group and individual plans. The most impactful differences are guarantee issue and pre-existing conditions. We used the OptumInsight Health Benefits Simulation Model (HBSM) to project the claims costs in the individual market. OptumInsight built this model using extensive public and proprietary health status data in order to project the impact on various markets (individual, small group, large group, Medicaid) of the health benefit exchanges and the subsidies available to low income individuals starting in 2014. Using the HBSM, we compared claim costs for individuals projected to be covered under the individual market. According to claim projections from the HBSM, individual claim costs in 2014 will be 0% - 40% higher than large group. On a weighted average basis, the difference between post-ACA individual coverage and employer coverage is 1.21. Based on this value, we increased the utilization in the pricing model by 20%.

2. **Unit Cost:** CHA will have two networks, a primary network with direct contracts and a secondary wrap network from a third-party vendor. Members will have access to both networks with no benefit differences based on point of service.

   Because CHA's direct network is still in development, we have relied on unit cost projections provided by CHA. These projections were based on a combination of discounts from signed provider contracts and anticipated discounts from contracts still under negotiation. The overall unit costs were developed by type of service (inpatient, outpatient, physician, and pharmacy). For each service type, we determined the discount from billed charges or percent of Medicare that would produce the appropriate cost levels in the model.

   For the secondary wrap network, we applied discounts provided by CHA to billed charges from the pricing model.

CREDIBILITY OF EXPERIENCE

Because CHA has no experience of their own, we have relied entirely on the base data in the pricing model with the adjustments mentioned above. The model includes over 114 million member months and we considered the manual rates based on the model to be fully credible.

PAID TO ALLOWED RATIO

As described above, each plan was priced independently using our pricing model. The model contains an underlying distribution of utilization and unit cost data by specific service type. The model then applies various cost sharing features (deductible, copay, coinsurance, etc.) to each service type. The allowed totals (on a statewide basis) are the same for all plans. The paid amount of each benefit is determined by reducing the allowed cost by the appropriate cost sharing feature. The paid to allowed ratio is equal to the sum of all paid benefits divided by the sum of all allowed benefits.

Note that these values differ from the actuarial value calculator due to differences in the assumed claim distributions. The table below shows the calculated paid to allowed ratio for each plan.

TABLE 1
PAID TO ALLOWED RATIO BY PLAN

PLAN	RATIO
Bronze HDP 2	53.0%
Bronze HDP 1	50.6%
Bronze 1	52.4%
Catastrophic	51.5%
Silver HDP 2	67.1%
Silver 1	67.2%
Silver 3	65.6%
Silver 2	63.2%
Silver 4	64.1%
Silver HDP 1	66.3%
Gold 1	83.9%
Gold 2	79.1%
Gold HDP 1	82.3%

RISK ADJUSTMENT AND REINSURANCE

No rate adjustments were made for the projected impact of risk adjustment. Because CHA has no block of business to consider at this point, we have assumed that they will ultimately end up with a block of approximately average risk and that they will not receive either a benefit or additional cost due to risk adjustment.

We have assumed that CHA will pay $5.25 PMPM on all their business in 2014. This includes individual and small group. Because the reinsurance pool is paid by all lines but only delivers a benefit to individual plans, we have assumed that their recoveries will exceed their premiums. Based on data from the HBSM, we compared the projected size of the private insurance market

to the projected size of the individual market. Assuming an 80% recovery rate, we estimate that individual carriers will receive an average recovery of $10.26 PMPM. This equates to a net recovery of $5.01 PMPM. This was again based on the assumption that CHA's population will resemble the average risk.

NON-BENEFIT EXPENSES AND PROFIT RISK

CHA filed their 2014 budget as part of the CO-OP application process. As of today, they are using the same operating budget. This included a detailed budget and anticipated enrollment of 151,057 member months. Based on these assumptions, we anticipate an administrative load of $58.51, or 18.4% of premium. They have also finalized their commission structure and we anticipate that average commission will be $24.72 PMPM, or 7.8%. Both of these values are high relative to market standards. This is primarily due to lower first year enrollment, higher first year commissions, and start-up costs. We anticipate that both administration and commissions will fall to more typical levels over time.

The pro forma financials which were filed with and approved by HHS included an allowance for budgeted losses. This will enable CHA to establish more competitive rates and grow market share, which is essential to their long-term success. The total approved losses for CHA in 2014 were $8.5 million. We have budgeted a loss of approximately $5.6 million, or $37.15 PMPM, with the remainder budgeted to CHA's small group business.

The rates include the following fees: $1 per member annually (or $0.08 PMPM) for risk adjustment, 3.5% for Exchange fees, and $5.01 PMPM for net reinsurance recoveries. We include an additional 2% load for premium tax. We do not expect 100% of CHA's individual business to be sold through the Exchange, so the 3.5% load could potentially be reduced. However, we have also not included the ACA insurer assessment as a separate adjustment. We believe that the expense for this tax can be recovered in whole or in part through the difference between the actual Exchange fee and the 3.5% built into the rates.

The table below shows the components of the average premium based on an average claim amount of $259.40 and the components above. We have assumed that all non-benefit expenses will be applied equally to all members as a percent of premium.

TABLE 2
COMPOSITE PREMIUM DEVELOPMENT

RATE COMPONENT	PMPM	PERCENT OF PREMIUM
Claims	$259.40	81.6%
Admin	$58.51	18.4%
Commission	$24.72	7.8%
Risk Adj	$0.08	0.0%
Reinsurance	-$5.01	-1.6%

TABLE 2 COMPOSITE PREMIUM DEVELOPMENT		
RATE COMPONENT	PMPM	PERCENT OF PREMIUM
Exchange Fee	$11.13	3.5%
Premium Tax	$6.36	2.0%
Margin	-$37.15	-11.7%
Premium	**$318.04**	

PROJECTED LOSS RATIO

The "traditional" (claims divided by premiums) expected MLR is 81.6%. We calculated MLRs for the proposed medical plans based on the projected claims and proposed rates using the method prescribed in the ACA for premium rebates, as follows:

1. ACA fees: See above. We estimate that the combined cost of ACA fees (exchange fees, federal reinsurance net recoveries, and risk adjustment) total $6.20 PMPM.

2. Expected taxes are $6.36 PMPM.

3. Based on the weighted average PMPM claims cost of $259.40 and premium of $318.04, the MLR (as used for rebate calculations) is then $259.40 divided by $305.48 [$318.04-$6.20 - $6.36], or 84.9%.

4. With the credibility adjustments allowed by the ACA in determining a carrier's minimum MLR, and considering CHA's projected enrollment for 2014, we estimate that the minimum for CHA will not be higher than 78.0%.

INDEX RATE

CHA's rates were not developed using an index rate. Rates were developed using paid claim amounts from the Optum pricing model, with separate models for each plan design. In addition to separate plans, CHA will be using two different networks – a direct network and a secondary wrap network. The wrap network will be provided through a third-party vendor and has considerably higher unit costs than the direct network.

Further, the rates are based on the assumption that the network penetration (i.e., the percent of services provide in the direct network) will vary significantly by area depending on overall depth of network coverage. Because of these issues, the pricing model cannot be used directly to calculate the index rate.

For each rating area, we assumed that utilization would not vary depending on which network a patient uses. However, the unit cost varied significantly depending on the choice of network.

With 100% direct network usage, the allowed claims total $389.53. With 0% direct network coverage, the allowed claims total $567.61.

In order to estimate the overall network penetration, it is necessary to consider the following:

1. The anticipated enrollment in each geographic rating area,
2. The assumed network penetration within each rating area,
3. The non-discounted unit cost relativity for each rating area relative to statewide average costs.

Based on these calculations, we determined that the total costs on a statewide basis are equivalent to 92.6% network penetration. The total allowed cost was then calculated by blending the direct and wrap network unit costs based on these weightings. Because utilization assumptions did not vary between networks, no blending of utilization was necessary.

Based on these weightings, the allowed PMPM claim amount was $402.71. In 2014, all costs are based on the Essential Health Benefits. Hence, this value is CHA's index rate during the projection period.

AV METAL VALUES

The 22 individual plan designs being offered by CHA were defined using the actuarial value calculator developed by the Department of Health and Human Services (HHS). Several of the proposed plan designs contain plan features that could not be priced within the limitations of the calculator. In accordance with guidance from HHS, we are providing this certification to confirm that all the proposed plans fall within the +/- 2% margin for each of the metallic levels or +/-1% for CSR plans.

In order to evaluate the actuarial value impact of the benefit differences, we used our pricing model to develop expected claim costs that matched the calculator inputs exactly. We then developed expected claims for the actual plan benefits. We then calculated the ratio of expected claims for the actual plan benefits to the expected claims from matching the calculator inputs exactly and applied that ratio to the actuarial value from the calculator.

The reasons that plans had to be adjusted from the actuarial value calculator fall into the following categories:

- The AV calculator makes no allowance for urgent care copays.
- The AV calculator does not allow cost sharing for lab and x-ray to vary by place of service (e.g., office vs. outpatient hospital)

Appendix II shows the specific benefit variations, the actuarial value according to the calculator, the net impact of benefit differences, and the final actuarial value for each of the proposed plans. Based on this analysis, all plans will fall within the appropriate metallic levels.

AV PRICING VALUES

The Silver 1 Plan has been used as the fixed reference plan for the AV pricing values. The table below illustrates the AV Pricing Value for each plan. Because administrative costs are allocated on a level basis across all plans (as a percent of premium), the differences in the AV pricing value are entirely attributable to differences in plan cost-sharing.

TABLE 3
COMPOSITE PREMIUM DEVELOPMENT

PLAN	AV PRICING VALUE
Bronze 1	79.3%
Bronze 2	75.7%
Bronze 3	78.4%
Catastrophic	75.3%
Silver HSA	99.9%
Silver 1	100.0%
Silver 2	97.7%
Silver 3	94.2%
Silver 4	95.4%
Silver 6	98.7%
Gold 1	124.5%
Gold 2	117.4%
Gold HSA	122.1%

MEMBERSHIP PROJECTIONS

This will be CHA's initial offering. As such, their membership projections are entirely built from the pro forma projections used in the CO-OP applications. Based on target market penetration assumptions and data from the HBSM, they anticipated 12,359 individual members in the Exchange and 1,373 individual members outside of the Exchange. Due to open enrollment, they projected that the majority of enrollment will be effective January 1 and the average member will be covered for 11 months. Note that the projected members were driven by market penetration assumptions, and slight differences between the members and member months are attributable to rounding.

Since CHA has no past experience to draw from, enrollment by plan is based on sales strategy and population characteristics. The table below shows the expected enrollment by metallic plan. Where more than one plan is offered for a given metallic level, it is assumed that enrollment will be equally divided.

TABLE 4
ASSUMED ENROLLMENT BY METALLIC LEVEL

METALLIC PLAN	MEMBERS	PLANS	ENROLLMENT
Gold	6.5%	3	2.2%
Silver	19.0%	6	3.2%
CSR 73%	23.0%	3	7.7%
CSR 87%	23.0%	3	7.7%
CSR 94%	3.0%	3	1.0%
Bronze	25.5%	3	8.5%

The projected enrollment in the CSR plans is based on data from the HBSM. It is based on the number of individuals residing in Tennessee who are (a) expected to purchase through the individual Exchange and (b) are projected to fall within the appropriate income ranges. Note that only three of the Silver plans (Silver 1, Silver 3, and Silver 6) are offered on the Exchange. Hence, the enrollment for the Exchange plans is equal to the sum of Silver enrollment and all three CSR plans (~19.5%) while the other Silver plans only have the base enrollment of 3.2%.

TERMINATED PRODUCTS

There are no terminated products.

WARNING ALERTS

There is a difference of $7 on total projected premium. This is a difference of less than 0.001% and is attributable to rounding.

PLAN TYPE

All individual products are EPO plans allowing only in-network benefits (other than emergency care).

RELIANCE ON OTHERS

I have relied on unit cost projections and area factor relativities provided by Michael Madalena in developing expected claim costs. I have not reviewed his projections, but the results seem reasonable in light of other information available to me.

ACTUARIAL CERTIFICATION

I, Earl L. Hoffman, am a member in good standing of the American Academy of Actuaries.

I certify that, to the best of my knowledge and judgment, the projected index rate is:

a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
b. Developed in compliance with the applicable Standard of Actuarial Practice,
c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
d. Neither excessive nor deficient.

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

Earl L. Hoffman, FSA, MAAA
Director, Actuarial Consulting

OptumInsight
12125 Technology Dr.
Eden Prairie, MN 55344
Phone: (952) 942-3230
earl.hoffman@optum.com

SUMMARY OF EXHIBITS

Appendix I – Rate Tables

Appendix II – Actuarial Value Impact of Benefit Differences

Appendix III – Plan Descriptions

APPENDIX I
RATE TABLES

ALL RATES SHOWN ARE FOR NON-SMOKERS. RATES WILL BE MULTIPLIED BY THE APPROPRIATE AREA FACTOR AND SMOKING ADJUSTMENT. CATASTROPHIC PLAN ONLY AVAILABLE UNDER AGE 30 EXCEPT IN CASE OF HARDSHIP

Age	Bronze HDP 2	Bronze HDP 1	Bronze 1	Catastrophic	Silver HDP 2 H.S.A (Non-Exchange)	Silver 1	Silver 3 (Non-Exchange)
0 – 20	$123.69	$118.07	$122.24	$117.42	$155.78	$155.99	$152.47
21	$194.79	$185.93	$192.51	$184.92	$245.33	$245.65	$240.12
22	$194.79	$185.93	$192.51	$184.92	$245.33	$245.65	$240.12
23	$194.79	$185.93	$192.51	$184.92	$245.33	$245.65	$240.12
24	$194.79	$185.93	$192.51	$184.92	$245.33	$245.65	$240.12
25	$195.57	$186.67	$193.28	$185.66	$246.31	$246.64	$241.08
26	$199.46	$190.39	$197.13	$189.36	$251.21	$251.55	$245.88
27	$204.14	$194.85	$201.75	$193.80	$257.10	$257.44	$251.64
28	$211.74	$202.11	$209.26	$201.01	$266.67	$267.02	$261.01
29	$217.97	$208.05	$215.42	$206.92	$274.52	$274.89	$268.69
30	$221.09	$211.03	$218.50	$209.88	$278.45	$278.82	$272.53
31	$225.76	$215.49	$223.12	$214.32	$284.33	$284.71	$278.30
32	$230.44	$219.95	$227.74	$218.76	$290.22	$290.61	$284.06
33	$233.36	$222.74	$230.63	$221.53	$293.90	$294.29	$287.66
34	$236.47	$225.72	$233.71	$224.49	$297.83	$298.22	$291.50
35	$238.03	$227.21	$235.25	$225.97	$299.79	$300.19	$293.42
36	$239.59	$228.69	$236.79	$227.45	$301.75	$302.15	$295.34
37	$241.15	$230.18	$238.33	$228.93	$303.71	$304.12	$297.26
38	$242.71	$231.67	$239.87	$230.41	$305.68	$306.08	$299.19
39	$245.82	$234.64	$242.95	$233.37	$309.60	$310.01	$303.03
40	$248.94	$237.62	$246.03	$236.33	$313.53	$313.94	$306.87
41	$253.62	$242.08	$250.65	$240.76	$319.42	$319.84	$312.63
42	$258.10	$246.36	$255.08	$245.02	$325.06	$325.49	$318.15
43	$264.33	$252.31	$261.24	$250.94	$332.91	$333.35	$325.84
44	$272.12	$259.74	$268.94	$258.33	$342.72	$343.18	$335.44
45	$281.28	$268.48	$277.98	$267.02	$354.25	$354.72	$346.73
46	$292.18	$278.89	$288.76	$277.38	$367.99	$368.48	$360.18
47	$304.46	$290.61	$300.89	$289.03	$383.45	$383.96	$375.30
48	$318.48	$303.99	$314.75	$302.34	$401.11	$401.64	$392.59
49	$332.31	$317.20	$328.42	$315.47	$418.53	$419.08	$409.64
50	$347.89	$332.07	$343.82	$330.27	$438.15	$438.74	$428.85
51	$363.28	$346.76	$359.03	$344.87	$457.53	$458.14	$447.82
52	$380.23	$362.93	$375.78	$360.96	$478.88	$479.51	$468.71
53	$397.37	$379.30	$392.72	$377.24	$500.47	$501.13	$489.84
54	$415.88	$396.96	$411.01	$394.80	$523.77	$524.47	$512.65
55	$434.38	$414.62	$429.30	$412.37	$547.08	$547.81	$535.46
56	$454.44	$433.77	$449.12	$431.42	$572.35	$573.11	$560.19
57	$474.70	$453.11	$469.15	$450.65	$597.86	$598.66	$585.16
58	$496.32	$473.75	$490.51	$471.17	$625.09	$625.92	$611.82
59	$507.04	$483.97	$501.10	$481.34	$638.59	$639.44	$625.02
60	$528.66	$504.61	$522.47	$501.87	$665.82	$666.70	$651.68
61	$547.36	$522.46	$540.95	$519.62	$689.37	$690.29	$674.73
62	$559.63	$534.17	$553.08	$531.27	$704.82	$705.76	$689.86
63	$575.02	$548.86	$568.29	$545.88	$724.21	$725.17	$708.82
64+	$584.37	$557.79	$577.53	$554.76	$735.98	$736.96	$720.35

Age	Silver 2	Silver 4 (Non-Exchange)	Silver HDP 1	Gold 1	Gold 2	Gold HDP 1 H.S.A
0 – 20	$146.99	$148.85	$153.97	$194.14	$183.08	$190.40
21	$231.49	$234.40	$242.46	$305.74	$288.31	$299.85
22	$231.49	$234.40	$242.46	$305.74	$288.31	$299.85
23	$231.49	$234.40	$242.46	$305.74	$288.31	$299.85
24	$231.49	$234.40	$242.46	$305.74	$288.31	$299.85
25	$232.41	$235.34	$243.43	$306.96	$289.46	$301.05
26	$237.04	$240.03	$248.28	$313.08	$295.23	$307.04
27	$242.60	$245.65	$254.10	$320.41	$302.15	$314.24
28	$251.63	$254.80	$263.56	$332.34	$313.39	$325.93
29	$259.03	$262.30	$271.32	$342.12	$322.62	$335.53
30	$262.74	$266.05	$275.20	$347.01	$327.23	$340.32
31	$268.29	$271.67	$281.02	$354.35	$334.15	$347.52
32	$273.85	$277.30	$286.84	$361.69	$341.07	$354.72
33	$277.32	$280.82	$290.47	$366.27	$345.39	$359.22
34	$281.02	$284.57	$294.35	$371.17	$350.01	$364.01
35	$282.88	$286.44	$296.29	$373.61	$352.31	$366.41
36	$284.73	$288.32	$298.23	$376.06	$354.62	$368.81
37	$286.58	$290.19	$300.17	$378.50	$356.92	$371.21
38	$288.43	$292.07	$302.11	$380.95	$359.23	$373.61
39	$292.14	$295.82	$305.99	$385.84	$363.84	$378.41
40	$295.84	$299.57	$309.87	$390.73	$368.46	$383.20
41	$301.39	$305.19	$315.69	$398.07	$375.38	$390.40
42	$306.72	$310.58	$321.27	$405.10	$382.01	$397.30
43	$314.13	$318.09	$329.02	$414.89	$391.23	$406.89
44	$323.39	$327.46	$338.72	$427.12	$402.77	$418.88
45	$334.27	$338.48	$350.12	$441.49	$416.32	$432.98
46	$347.23	$351.61	$363.70	$458.61	$432.46	$449.77
47	$361.81	$366.37	$378.97	$477.87	$450.62	$468.66
48	$378.48	$383.25	$396.43	$499.88	$471.38	$490.25
49	$394.91	$399.89	$413.65	$521.59	$491.85	$511.54
50	$413.43	$418.64	$433.04	$546.05	$514.92	$535.52
51	$431.72	$437.16	$452.20	$570.20	$537.69	$559.21
52	$451.86	$457.56	$473.29	$596.80	$562.78	$585.30
53	$472.23	$478.18	$494.63	$623.70	$588.15	$611.69
54	$494.22	$500.45	$517.66	$652.75	$615.54	$640.17
55	$516.21	$522.72	$540.70	$681.80	$642.93	$668.66
56	$540.06	$546.86	$565.67	$713.29	$672.62	$699.54
57	$564.13	$571.24	$590.89	$745.08	$702.61	$730.72
58	$589.83	$597.26	$617.80	$779.02	$734.61	$764.01
59	$602.56	$610.15	$631.14	$795.84	$750.46	$780.50
60	$628.25	$636.17	$658.05	$829.77	$782.47	$813.78
61	$650.48	$658.67	$681.33	$859.12	$810.14	$842.57
62	$665.06	$673.44	$696.60	$878.38	$828.31	$861.46
63	$683.35	$691.96	$715.76	$902.54	$851.08	$885.14
64+	$694.46	$703.21	$727.39	$917.21	$864.92	$899.54

GEOGRAPHIC AREA FACTORS

RATING AREA	AREA FACTOR
Greater Knoxville	1.000
Greater Nashville	1.012
West	1.012
Greater Memphis	0.994
West Central	0.990

SMOKER STATUS

SMOKER STATUS	AREA FACTOR
Non-Smoker	1.00
Smoker	1.25

APPENDIX II
ACTUARIAL VALUE IMPACT OF BENEFIT DIFFERENCES

	BENEFIT DIFFERENCES				
PLAN	CALCULATOR INPUTS	PROPOSED BENEFIT	ACTUARIAL VALUE (CALCULATOR)	IMPACT OF BENEFIT DIFFERENCE	FINAL ACTUARIAL VALUE
Bronze HDP 2	No Differences		61.0%	1.0000	61.0%
Bronze HDP 1	No Differences		58.3%	1.0000	58.3%
Bronze 1	No Differences		62.0%	1.0000	62.0%
Silver 1 indiv	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	72.2%	0.9855	71.2%
Silver 1 200-250% 72-74	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	74.6%	0.9862	73.6%
Silver 1 150-200% 86-88	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): $50 Copay • Emergency Room: Deductible/Coinsurance • Urgent Care: $25 Copay	88.6%	0.9935	88.0%
Silver 1 100-150% 93-95	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): $25 Copay • Emergency Room: Deductible/Coinsurance • Urgent Care: $10 Copay	94.7%	0.9985	94.5%

	Benefit Differences				
Plan	**Calculator Inputs**	**Proposed Benefit**	**Actuarial Value (Calculator)**	**Impact of Benefit Difference**	**Final Actuarial Value**
Silver 3 indiv	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	71.3%	0.9843	70.2%
Silver 2 indiv	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	70.3%	0.9825	69.1%
Silver 2 200-250% 72-74	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	73.5%	0.9851	72.4%
Silver 2 150-200% 86-88	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): $50 Copay • Emergency Room: Deductible/Coinsurance • Urgent Care: $30 Copay	87.5%	0.9932	86.9%
Silver 2 100-150% 93-95	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): $50 Copay • Emergency Room: Deductible/Coinsurance • Urgent Care: $15 Copay	93.8%	0.9968	93.5%

	Benefit Differences				
Plan	**Calculator Inputs**	**Proposed Benefit**	**Actuarial Value (Calculator)**	**Impact of Benefit Difference**	**Final Actuarial Value**
Silver 4 indiv	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	69.3%	0.9815	68.0%
Silver HDP 2 Indiv HSA	No Differences		68.9%	1.0000	68.9%
Silver HDP 1 Indiv HSA	No Differences		68.8%	1.0000	68.8%
Silver HDP 1 200-250% 72-74	No Differences		73.2%	1.0000	73.2%
Silver HDP 1 150-200% 86-88	No Differences		87.7%	1.0000	87.7%
Silver HDP 1 100-150% 93-95	No Differences		93.6%	1.0000	93.6%
Gold HDP 1 - HSA	No Differences		78.8%	1.0000	78.8%
Gold 2	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	79.8%	0.9895	79.0%
Gold 1	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	82.5%	0.9924	81.9%
Catastrophic	No Differences		60.4%	1.0000	60.4%

APPENDIX III
PLAN DESCRIPTIONS

		Gold HDP1 H.S.A	Gold 2	Gold 1	Silver 1	Silver 1 200-250% 72-74	Silver 1 150-200% 86-88	Silver 1 100-150% 93-95	Silver 3	Silver 2	Silver 2 200-250% 72-74	Silver 2 150-200% 86-88
Deductible	Single	$2,000	$1,000	$500	$2,000	$2,000	$250	$75	$2,500	$3,500	$2,750	$450
	Family	$4,000	$2,000	$1,000	$4,000	$4,000	$500	$150	$5,000	$7,000	$5,500	$900
Out of Pocket Maximum	Single	$2,000	$4,000	$4,500	$6,400	$5,200	$2,250	$1,000	$6,400	$6,400	$5,200	$2,250
	Family	$4,000	$8,000	$9,000	$12,800	$10,400	$4,500	$2,000	$12,800	$12,800	$10,400	$4,500
Coinsurance		100%	70%	80%	70%	70%	80%	90%	70%	70%	70%	80%
Office/Free Standing Clinic	PCP	Ded/Coins	$20	$20	$25	$20	$10	$5	$25	$25	$20	$10
	Specialist	Ded/Coins	$50	$50	$50	$45	$25	$10	$50	$50	$50	$30
	Lab	Ded/Coins	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Xray	Ded/Coins	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Hospital	IP	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	OP Surg	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Surgeon	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	100%	100%	Ded/Coins	Ded/Coins	Ded/Coins	100%
	Major DX	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab/X-Ray	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	$50	$25	Ded/Coins	Ded/Coins	Ded/Coins	$50
Emergency Room		Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Urgent Care		Ded/Coins	Ded/Coins	$50	$50	$50	$25	$10	$50	$50	$50	$30
PT/OT/ST		Ded/Coins	Ded/Coins	Coins	$50	$45	$25	$10	$50	$50	$50	$30
All Other		Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Pharmacy	Generic	Ded/Coins	$10	$10	$10	$10	$10	$4	$10	$10	$10	$10
	Preferred Brand	Ded/Coins	$30	$30	$40	$35	$25	$15	$40	$40	$35	$25
	Non-Pref Brand	Ded/Coins	$60	$60	$75	$60	$50	$35	$75	$75	$60	$50
	Specialty	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	$50	$25	Ded/Coins	Ded/Coins	Ded/Coins	$50

		Silver 2 100-150% 93-95	Silver 4	Silver HDP 2 HSA	Silver HDP 1 HSA	Silver HDP 1 200-250% 72-74	Silver HDP 1 150-200% 86-88	Silver HDP 1 100-150% 93-95	Bronze HDP 2	Bronze HDP 1	Bronze 1	Catastrophic Plan
Deductible	Single	$150	$4,750	$2,000	$3,500	$2,750	$1,000	$250	$5,500	$6,250	$4,000	$6,400
	Family	$300	$9,500	$4,000	$7,000	$5,500	$2,000	$500	$11,000	$12,500	$8,000	$12,800
Out of Pocket Maximum	Single	$1,000	$6,400	$6,000	$3,500	$2,750	$1,000	$500	$5,500	$6,250	$6,400	$6,400
	Family	$2,000	$12,800	$12,000	$7,000	$5,500	$2,000	$1,000	$11,000	$12,500	$12,800	$12,800
Coinsurance		100%	90%	70%	80%	100%	100%	100%	70%	100%	100%	60%
Office/Free Standing Clinic	PCP	$5	$25	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	$30	Ded/Coins
	Specialist	$15	$50	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab	100%	100%	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Xray	100%	100%	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Hospital	IP	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	OP Surg	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Surgeon	100%	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Major DX	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab/X-Ray	$50	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Emergency Room		Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Urgent Care		Ded/Coins	$15	$50	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
PT/OT/ST		Ded/Coins	$15	$50	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
All Other		Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Pharmacy	Generic	$4	$10	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Preferred Brand	$15	$40	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Non-Pref Brand	$35	$75	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Specialty	$50	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins

ACTUARIAL MEMORANDUM

Community Health Alliance Mutual Insurance Company
Rates for Individual Policies
Effective January 1, 2014

INTRODUCTION

The purpose of this actuarial memorandum is to provide initial rates and supporting documentation for Community Health Alliance's (CHA) individual products.

CHA has engaged OptumInsight (Optum) to develop the premium rates for its new Individual health policies, to test these rates for the expected medical loss ratios (MLR), and to file them with the Tennessee Insurance Division with an effective date of January 1, 2014. This will be CHA's first offering of individual plans.

BENEFIT PLANS AND RATE STRUCTURE

CHA will be offering 22 individual plans at the Gold, Silver, and Bronze metallic levels, including 9 plans to satisfy the Cost Sharing Reduction (CSR) subsidies for Silver plans on the Exchange. The appendix to this memorandum provides high level descriptions of the key benefit features of these plans.

The rates for each of these plans are structured as follows:

- Rate brackets as defined in the HHS Standard Age Curve;
- Five rating areas, as defined by regulation: Greater Knoxville, Greater Nashville, West, Greater Memphis, and West Central. CHA will not be marketing individual plans in the East, Greater Chattanooga, or East Central rating areas in 2014;
- Rating tiers for smoker (1.25 factor) vs. non-smoker (1.00 factor).

In family situations, each family member is rated separately, based on his/her age and smoking status.

RATE DEVELOPMENT ASSUMPTIONS

OptumInsight Cost Model

We used the Optum Comprehensive Pricing model to develop PMPM claims for an average 12 month policy period beginning 1/1/2014. The model has age, gender, and area claims relativities that allow it to calculate the PMPM claims separately for male and female members by age bracket, in different metropolitan statistical areas (MSAs) or in the non-MSA parts of states.

The data underlying the cost model come from the experience of commercial carriers during 2010-2011. There are 114 million member-months of exposures, primarily from large groups, with the rest from small groups and individuals. As such, the underlying data represent fairly closely the claims from an average commercially-insured, partially underwritten population by age bracket and gender.

Morbidity (Claim Costs) Assumptions

We made the following adjustments to the model claims costs:

1. **Age and gender:** The Optum model has factors, developed from the claims by age and gender in the database, that adjust the PMPM allowed costs for these factors. The model makes these adjustments for each service line (inpatient, outpatient, physician, prescription drugs).

2. **Location:** Initial claim costs were developed at a statewide level for Tennessee. To develop relativities for each rating area, we matched each county to its corresponding MSA (or non-MSA area) and identified each county's population based on 2010 national census data. Based on this information, we developed a distribution of population, by MSA, within each rating area. We then modeled a 100% coverage plan ($0 deductible, 100% coinsurance) for each rating area, as well as on a statewide basis. The ratio of each rating area's projected claim cost to the statewide total (on a PMPM basis) was used as the rating area relativity.

3. **Provider contracting and network utilization:** CHA will have two networks, a primary network with direct contracts and a secondary wrap network from a third-party vendor. Members will have access to both networks with no benefit differences based on point of service. CHA's primary network is currently under development, so we have relied entirely on CHA to estimate what the ultimate costs and/or discounts will be.

   We developed assumptions about direct vs. wrap network penetration (i.e., the percent of services by network) for each rating area. These assumptions were based on input from provider contracting and considered overall usage levels of providers in the direct network, as well as the number of contracted providers in the direct vs. wrap networks. The penetration assumptions, by rating area, are summarized in the table below.

TABLE 1
NETWORK UTILIZATION BY RATING AREA

RATING AREA	DIRECT NETWORK PENETRATION	WRAP NETWORK PENETRATION
Greater Knoxville	90%	10%
Greater Nashville	90%	10%
West	80%	20%
Greater Memphis	100%	0%
West Central	90%	10%

These are all exclusive provider plans, so we assumed no out-of-network usage.

4. **Utilization:** The Optum model and underlying utilization are primarily based on large group experience. We used the OptumInsight Health Benefits Simulation Model (HBSM) to project the claims costs in the individual market. OptumInsight built this model using extensive public and proprietary health status data in order to project the impact on various markets (individual, small group, large group, Medicaid) of the health benefit exchanges and the subsidies available to low income individuals starting in 2014. According to claim projections from the HBSM, individual claim costs in 2014 will be 0% - 40% higher than large group. Based on this range of expectations, utilization assumptions were increased by 20% in order to project the additional claim costs anticipated due to guarantee issue and pre-existing conditions.

5. **Unit Cost:** Because CHA's network is still in development, we have relied on unit cost projections provided by CHA. These projections were based on a combination of discounts from signed provider contracts and anticipated discounts from contracts still under negotiation. The overall unit costs were developed my type of service (inpatient, outpatient, physician, and pharmacy). For each service type, we determined the discount from billed charges or percent of Medicare that would produce the appropriate cost levels in the model.

   For the secondary wrap network, we applied discounts to billed charges provided by CHA.

Policy Lapse Assumption

Based on open enrollment periods, we have assumed that policies will be primarily issued with January effective dates and will not lapse mid-year.

Member Distribution Assumption

The assumed distribution of members by issue age is shown in the table below. This distribution is based on Optum's Health Benefit Simulation Model (HBSM), which was developed to project the movement of individuals between various levels of coverage (uninsured, individual exchange, employer coverage, etc.) due to the implementation of the Accountable Care Act (ACA).

The HBSM projects movement between levels by state and by county based on a variety of parameters, including anticipated rate changes due to the ACA, employer earnings, and Medicaid expansion.

TABLE 2 ASSUMED MEMBER DISTRIBUTION	
AGES	PROJECTED ENROLLMENT
00 - 19	24.3%
20 - 24	8.6%
25 - 29	9.7%
30 - 34	8.0%
35 - 39	8.0%
40 - 44	8.2%
45 - 49	8.2%
50 - 54	9.1%
55 - 59	8.4%
60 - 64	6.9%
65+	0.8%

Interest, Administrative Expense, Commission, and ACA Fee Assumptions

The following are the expense, tax, fee, and commission assumptions:

- Premium tax: 2%

- ACA-related fees: The ACA temporary reinsurance fee payable in 2014 is $5.25 PMPM. Because the reinsurance program is paid by all lines of business but only covers non-grandfathered individual plans, we have adjusted for the reinsurance *net* of recoveries. Based on information in the HBSM, we have estimated average recoveries on individual plans of $10.26 PMPM. The net reinsurance cost assumed in the rates is a net recovery of $5.01.

  We estimate that the ACA reinsurer fee will be approximately 3.5% of premium, starting in 2014. In reality, this load will likely be smaller due to the expectation of non-Exchange premium. Since it is not clear how much of CHA's enrollment will come from the Exchange, we have allotted the full 3.5% Exchange fee but have not included an additional charge for the ACA insurer tax.

  We have also included an additional $1 PMPY (or approximately $0.08 PMPM) for the federal risk adjustment program. We have assumed that CHA's overall risk will resemble the statewide average and not assumed any explicit gains or losses due to risk adjustment in our rate setting.

- Administrative Expense: $58.51 PMPM; this amount is higher than average for individual plans and is largely driven by first year start-up costs and lower first year enrollment. We anticipate that this value will decrease steadily over time as HCA grows their market share.

- Commissions: CHA will work through three distribution channels to sell and retain Individual business. The three channels are as follows:

  - Direct sales through the Navigator
  - Direct sales through the Market Partner (described below)
  - Contracts sold through a broker

  CHA will use a vendor called a Marketing Partner will perform traditional front office duties on behalf of the co-ops. CHA will pay a combination of commission, fee override and fees to the Marketing Partner depending on whether the service is a direct sale, or support of a sale through a broker, or a one-time function such as a new broker certification.

  Commissions are paid as flat dollar amounts per member per month. These commissions vary depending upon whether the business is placed through a broker, direct through the Marketing Partner, from the Exchange/Navigator (in which case, there is no commission). Based on information from CHA, we assume that following breakdown; 54% of new business will come via brokers, 14% via the Sales Center, and 32% direct. CHA assumed 80% of Individual business will come through the Exchange.

  For contracts sold through a broker, the broker will receive $40.00 for each subscriber and $15.00 per each dependent. The Marketing Partner will receive a 10% override for contracts sold through the Exchange and 20% override for contracts sold outside the Exchange. The marketing Partner will receive the commission if the contract is sold directly through the Marketing Partner with no broker support. The Marketing Partner is paid a one fee of $20.00 for each broker appointment, and $4.50 per broker a month for transactional cost of paying broker commissions. No commission or overrides are paid for business sold directly through the Exchange or through a Navigator. The weighted average of the commission and overrides through the three changes and segments is $24.72 PMPM.

- Margin/Provision for Contingencies: CHA's solvency requirements during their first five years of operation are largely being funded by the federal CO-OP program. Because enrollment growth and market share are critical to the CO-OP's success, the business plan filed with and approved by CMS projected budgeted operating losses in 2014 and 2015. In aggregate, these losses were projected to total approximately $8.5 million in 2014 with the resulting shortfall in surplus being funded through federal solvency loans.

  Based on projected enrollment, we have budgeted a loss of $5.6 million, or $37.15 PMPM, for CHA's individual plans in the first policy year. The remaining losses have been allocated to CHA's small group plans. This results in a margin of -11.7% on CHA's individual plans.

Because we do not consider investment income material to these products, we have made no interest assumptions.

RATE DEVELOPMENT PROCESS

The following is a general description of the rate development method:

1. We first ran each plan design through our cost model to derive statewide claims by age bracket using the assumptions described above. These claim costs were based on the assumed direct network discounts/percent of Medicare. We then ran each of the plan designs through the cost model using the assumed discounts for the secondary wrap network. This gave us two expected statewide claim amounts for each plan design – one based on the primary network and one based on the secondary wrap network.

2. Statewide expected claims for each plan design were combined into a single statewide rate for both the direct and wrap networks. The assumed distribution of plans by metallic level is shown in the table below. Since CHA is offering multiple plans at each metallic level, it was assumed that enrollment would be evenly distributed across each plan at a given level.

TABLE 3
ASSUMED ENROLLMENT BY METALLIC LEVEL

METALLIC PLAN	ENROLLMENT
Gold	6.5%
Silver	19.0%
Silver (CSR 73%)	23.0%
Silver (CSR 87%)	23.0%
Silver (CSR 94%)	3.0%
Bronze	25.5%

   Based on the assumptions described above, the expected statewide claims for the direct network were $247.78 PMPM. For the wrap network, the expected claims were $404.71 PMPM. These values account for the expected recovery of member cost sharing in the CSR plans and assume that net paid claims in the CSR plans will equal those in the base Silver plans.

3. For each rating area, as well as statewide, we ran the weighted population through the cost model for a 100% plan (no deductible, 100% coinsurance). We estimated the geographic claim adjustment based on the ratio of PMPM claims in each rating area to the statewide claim amount. The table below shows the resulting relativities.

TABLE 4 AREA PMPM CLAIMS COST FACTORS	
AREA	**FACTOR**
Greater Knoxville	0.984
Greater Nashville	0.997
West	0.941
Greater Memphis	1.040
West Central	0.975

These are not final cost factors by area but rather theoretical cost relativities if the direct and wrap network usage mix were the same in all areas.

4. For each rating area, the statewide direct network claim costs were blended with the statewide wrap network claim costs based on each combination of weights shown in Table 1. For each rating area, the cost factor from Table 4 was multiplied by the corresponding blended claim cost to calculate an area-specific blended claim amount.

5. Based on HCA's sales strategy, the blended claim amounts from Step 4 were weighted based on the projected enrollment distribution by rating area. The final area factor for each rating area was calculated as the ratio of the expected claims to the estimated statewide claim cost. The table below shows the projected distribution by rating area, expected direct network penetration for each area, expected claim amounts (blended between networks), the resulting area factors, and the statewide composite claim amount.

TABLE 5 AREA FACTOR DEVELOPMENT				
RATING AREA	**ENROLLMENT**	**DIRECT NETWORK WEIGHT**	**CLAIMS**	**AREA FACTOR**
Greater Knoxville	24%	90%	$259.34	1.000
Greater Nashville	20%	90%	$262.61	1.012
West	8%	80%	$262.60	1.012
Greater Memphis	40%	100%	$257.72	0.994
West Central	8%	90%	$256.75	0.990
Statewide	**100%**		**$259.40**	

6. The statewide composite premium rate was calculated as the sum of expected claims, administrative costs, commissions, ACA fees, premium tax, and expected margin (or loss, in this case). The table below shows the development of a composite premium rate of $318.04 PMPM.

TABLE 6 COMPOSITE PREMIUM DEVELOPMENT		
RATE COMPONENT	**PMPM**	**PERCENT OF PREMIUM**
Claims	$259.40	81.6%
Administration	$58.51	18.4%
Commission	$24.72	7.8%
Risk Adjustment	$0.08	0.0%
Reinsurance	-$5.01	-1.6%
Exchange Fee	$11.13	3.5%
Premium Tax	$6.36	2.0%
Margin	-$37.15	-11.7%
Premium	**$318.04**	

7. Based on the age factors from the HHS Standard Age Curve, the relativities between claims for each plan design, and the expected distribution of age and plan enrollment, rates were created for each plan design and age group based on the composite premium of $318.04 with a target loss ratio of 81.6%.

8. For each area, the premium rate for each age and plan is equal to the premium rate from Step 7 multiplied by the area factor from Step 5 and the appropriate smoker status adjustment.

The final rates by area and age are shown in Appendix I.

CALCULATION OF ANTICIPATED MEDICAL LOSS RATIO (MLR)

We calculated MLRs for the proposed medical plans based on the projected claims and proposed rates using the method prescribed in the ACA for premium rebates, as follows:

1. ACA fees: See above. We estimate that the combined cost of ACA fees (exchange fees, federal reinsurance net recoveries, and risk adjustment) total $6.20 PMPM.

2. The projected cost of taxes is $6.36 PMPM.

3. Based on the weighted average PMPM claims cost of $259.40 and premium of $318.04, the MLR (as used for rebate calculations) is then $259.40 divided by $305.48 [$318.04 - $6.20 - $6.36], or 84.9%

4. With the credibility adjustments allowed by the ACA in determining a carrier's minimum MLR, and considering CHA's projected enrollment for 2014, we estimate that the minimum for CHA will not be higher than 78.8%.

5. The "traditional" (claims divided by premiums) expected MLR is 81.6%.

DEVIATIONS FROM ACTUARIAL VALUE CALCULATOR

The 22 individual plan designs being offered by CHA were defined using the actuarial value calculator developed by the Department of Health and Human Services (HHS). Several of the proposed plan designs contain plan features that could not be priced within the limitations of the calculator. In accordance with guidance from HHS, we are providing this certification to confirm that all the proposed plans fall within the +/- 2% margin for each of the metallic levels or +/-1% for CSR plans.

In order to evaluate the actuarial value impact of the benefit differences, we used our pricing model to develop expected claim costs that matched the calculator inputs exactly. We then developed expected claims for the actual plan benefits. We then compared the ratio of paid claims between plans and applied that factor to the actuarial value from the calculator.

Appendix II shows the specific benefit variations, the actuarial value according to the calculator, the net impact of benefit differences, and the final actuarial value for each of the proposed plans. Based on this analysis, all plans will fall within the appropriate metallic levels.

ACTUARIAL CERTIFICATION

I am a member in good standing of the American Academy of Actuaries. I certify that, to the best of my knowledge and judgment, this entire rate filing is in compliance with the applicable laws of the State of Tennessee and with the rules of the Tennessee Insurance Division and that the benefits are reasonable in relation to the premiums.

Earl L. Hoffman, FSA, MAAA
Director, Actuarial Consulting

OptumInsight
12125 Technology Dr.
Eden Prairie, MN 55344
Phone: (952) 942-3230
earl.hoffman@optum.com

SUMMARY OF EXHIBITS

Appendix I – Rate Tables

Appendix II – Actuarial Value Impact of Benefit Differences

Appendix III – Plan Descriptions

APPENDIX I
RATE TABLES

ALL RATES SHOWN ARE FOR NON-SMOKERS. RATES WILL BE MULTIPLIED BY THE APPROPRIATE AREA FACTOR AND SMOKING ADJUSTMENT. CATASTROPHIC PLAN IS ONLY AVAILABLE UNDER AGE 30 EXCEPT IN CASE OF HARDSHIP.

Age	Bronze HDP 2	Bronze HDP 1	Bronze 1	Catastrophic	Silver HDP 2 H.S.A (Non-Exchange)	Silver 1	Silver 3 (Non-Exchange)
0 – 20	$123.69	$118.07	$122.24	$117.42	$155.78	$155.99	$152.47
21	$194.79	$185.93	$192.51	$184.92	$245.33	$245.65	$240.12
22	$194.79	$185.93	$192.51	$184.92	$245.33	$245.65	$240.12
23	$194.79	$185.93	$192.51	$184.92	$245.33	$245.65	$240.12
24	$194.79	$185.93	$192.51	$184.92	$245.33	$245.65	$240.12
25	$195.57	$186.67	$193.28	$185.66	$246.31	$246.64	$241.08
26	$199.46	$190.39	$197.13	$189.36	$251.21	$251.55	$245.88
27	$204.14	$194.85	$201.75	$193.80	$257.10	$257.44	$251.64
28	$211.74	$202.11	$209.26	$201.01	$266.67	$267.02	$261.01
29	$217.97	$208.05	$215.42	$206.92	$274.52	$274.89	$268.69
30	$221.09	$211.03	$218.50	$209.88	$278.45	$278.82	$272.53
31	$225.76	$215.49	$223.12	$214.32	$284.33	$284.71	$278.30
32	$230.44	$219.95	$227.74	$218.76	$290.22	$290.61	$284.06
33	$233.36	$222.74	$230.63	$221.53	$293.90	$294.29	$287.66
34	$236.47	$225.72	$233.71	$224.49	$297.83	$298.22	$291.50
35	$238.03	$227.21	$235.25	$225.97	$299.79	$300.19	$293.42
36	$239.59	$228.69	$236.79	$227.45	$301.75	$302.15	$295.34
37	$241.15	$230.18	$238.33	$228.93	$303.71	$304.12	$297.26
38	$242.71	$231.67	$239.87	$230.41	$305.68	$306.08	$299.19
39	$245.82	$234.64	$242.95	$233.37	$309.60	$310.01	$303.03
40	$248.94	$237.62	$246.03	$236.33	$313.53	$313.94	$306.87
41	$253.62	$242.08	$250.65	$240.76	$319.42	$319.84	$312.63
42	$258.10	$246.36	$255.08	$245.02	$325.06	$325.49	$318.15
43	$264.33	$252.31	$261.24	$250.94	$332.91	$333.35	$325.84
44	$272.12	$259.74	$268.94	$258.33	$342.72	$343.18	$335.44
45	$281.28	$268.48	$277.98	$267.02	$354.25	$354.72	$346.73
46	$292.18	$278.89	$288.76	$277.38	$367.99	$368.48	$360.18
47	$304.46	$290.61	$300.89	$289.03	$383.45	$383.96	$375.30
48	$318.48	$303.99	$314.75	$302.34	$401.11	$401.64	$392.59
49	$332.31	$317.20	$328.42	$315.47	$418.53	$419.08	$409.64
50	$347.89	$332.07	$343.82	$330.27	$438.15	$438.74	$428.85
51	$363.28	$346.76	$359.03	$344.87	$457.53	$458.14	$447.82
52	$380.23	$362.93	$375.78	$360.96	$478.88	$479.51	$468.71
53	$397.37	$379.30	$392.72	$377.24	$500.47	$501.13	$489.84
54	$415.88	$396.96	$411.01	$394.80	$523.77	$524.47	$512.65
55	$434.38	$414.62	$429.30	$412.37	$547.08	$547.81	$535.46
56	$454.44	$433.77	$449.12	$431.42	$572.35	$573.11	$560.19
57	$474.70	$453.11	$469.15	$450.65	$597.86	$598.66	$585.16
58	$496.32	$473.75	$490.51	$471.17	$625.09	$625.92	$611.82
59	$507.04	$483.97	$501.10	$481.34	$638.59	$639.44	$625.02
60	$528.66	$504.61	$522.47	$501.87	$665.82	$666.70	$651.68
61	$547.36	$522.46	$540.95	$519.62	$689.37	$690.29	$674.73
62	$559.63	$534.17	$553.08	$531.27	$704.82	$705.76	$689.86
63	$575.02	$548.86	$568.29	$545.88	$724.21	$725.17	$708.82
64+	$584.37	$557.79	$577.53	$554.76	$735.98	$736.96	$720.35

Age	Silver 2	Silver 4 (Non-Exchange)	Silver HDP 1 (H.S.A)	Gold 1	Gold 2	Gold HDP 1 (H.S.A)
0 – 20	$146.99	$148.85	$153.97	$194.14	$183.08	$190.40
21	$231.49	$234.40	$242.46	$305.74	$288.31	$299.85
22	$231.49	$234.40	$242.46	$305.74	$288.31	$299.85
23	$231.49	$234.40	$242.46	$305.74	$288.31	$299.85
24	$231.49	$234.40	$242.46	$305.74	$288.31	$299.85
25	$232.41	$235.34	$243.43	$306.96	$289.46	$301.05
26	$237.04	$240.03	$248.28	$313.08	$295.23	$307.04
27	$242.60	$245.65	$254.10	$320.41	$302.15	$314.24
28	$251.63	$254.80	$263.56	$332.34	$313.39	$325.93
29	$259.03	$262.30	$271.32	$342.12	$322.62	$335.53
30	$262.74	$266.05	$275.20	$347.01	$327.23	$340.32
31	$268.29	$271.67	$281.02	$354.35	$334.15	$347.52
32	$273.85	$277.30	$286.84	$361.69	$341.07	$354.72
33	$277.32	$280.82	$290.47	$366.27	$345.39	$359.22
34	$281.02	$284.57	$294.35	$371.17	$350.01	$364.01
35	$282.88	$286.44	$296.29	$373.61	$352.31	$366.41
36	$284.73	$288.32	$298.23	$376.06	$354.62	$368.81
37	$286.58	$290.19	$300.17	$378.50	$356.92	$371.21
38	$288.43	$292.07	$302.11	$380.95	$359.23	$373.61
39	$292.14	$295.82	$305.99	$385.84	$363.84	$378.41
40	$295.84	$299.57	$309.87	$390.73	$368.46	$383.20
41	$301.39	$305.19	$315.69	$398.07	$375.38	$390.40
42	$306.72	$310.58	$321.27	$405.10	$382.01	$397.30
43	$314.13	$318.09	$329.02	$414.89	$391.23	$406.89
44	$323.39	$327.46	$338.72	$427.12	$402.77	$418.88
45	$334.27	$338.48	$350.12	$441.49	$416.32	$432.98
46	$347.23	$351.61	$363.70	$458.61	$432.46	$449.77
47	$361.81	$366.37	$378.97	$477.87	$450.62	$468.66
48	$378.48	$383.25	$396.43	$499.88	$471.38	$490.25
49	$394.91	$399.89	$413.65	$521.59	$491.85	$511.54
50	$413.43	$418.64	$433.04	$546.05	$514.92	$535.52
51	$431.72	$437.16	$452.20	$570.20	$537.69	$559.21
52	$451.86	$457.56	$473.29	$596.80	$562.78	$585.30
53	$472.23	$478.18	$494.63	$623.70	$588.15	$611.69
54	$494.22	$500.45	$517.66	$652.75	$615.54	$640.17
55	$516.21	$522.72	$540.70	$681.80	$642.93	$668.66
56	$540.06	$546.86	$565.67	$713.29	$672.62	$699.54
57	$564.13	$571.24	$590.89	$745.08	$702.61	$730.72
58	$589.83	$597.26	$617.80	$779.02	$734.61	$764.01
59	$602.56	$610.15	$631.14	$795.84	$750.46	$780.50
60	$628.25	$636.17	$658.05	$829.77	$782.47	$813.78
61	$650.48	$658.67	$681.33	$859.12	$810.14	$842.57
62	$665.06	$673.44	$696.60	$878.38	$828.31	$861.46
63	$683.35	$691.96	$715.76	$902.54	$851.08	$885.14
64+	$694.46	$703.21	$727.39	$917.21	$864.92	$899.54

GEOGRAPHIC AREA FACTORS

RATING AREA	AREA FACTOR
Greater Knoxville	1.000
Greater Nashville	1.012
West	1.012
Greater Memphis	0.994
West Central	0.990

SMOKER STATUS

SMOKER STATUS	AREA FACTOR
Non-Smoker	1.00
Smoker	1.25

APPENDIX II
ACTUARIAL VALUE IMPACT OF BENEFIT DIFFERENCES

	BENEFIT DIFFERENCES				
PLAN	CALCULATOR INPUTS	PROPOSED BENEFIT	ACTUARIAL VALUE (CALCULATOR)	IMPACT OF BENEFIT DIFFERENCE	FINAL ACTUARIAL VALUE
Bronze HDP 2	No Differences		61.0%	1.0000	61.0%
Bronze HDP 1	No Differences		58.3%	1.0000	58.3%
Bronze 1	No Differences		62.0%	1.0000	62.0%
Silver 1 indiv	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	72.2%	0.9855	71.2%
Silver 1 200-250% 72-74	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	74.6%	0.9862	73.6%
Silver 1 150-200% 86-88	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): $50 Copay • Emergency Room: Deductible/Coinsurance • Urgent Care: $25 Copay	88.6%	0.9935	88.0%
Silver 1 100-150% 93-95	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): $25 Copay • Emergency Room: Deductible/Coinsurance • Urgent Care: $10 Copay	94.7%	0.9985	94.5%

	Benefit Differences				
Plan	**Calculator Inputs**	**Proposed Benefit**	**Actuarial Value (Calculator)**	**Impact of Benefit Difference**	**Final Actuarial Value**
Silver 3 indiv	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	71.3%	0.9843	70.2%
Silver 2 indiv	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	70.3%	0.9825	69.1%
Silver 2 200-250% 72-74	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	73.5%	0.9851	72.4%
Silver 2 150-200% 86-88	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): $50 Copay • Emergency Room: Deductible/Coinsurance • Urgent Care: $30 Copay	87.5%	0.9932	86.9%
Silver 2 100-150% 93-95	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): $50 Copay • Emergency Room: Deductible/Coinsurance • Urgent Care: $15 Copay	93.8%	0.9968	93.5%

	Benefit Differences				
Plan	**Calculator Inputs**	**Proposed Benefit**	**Actuarial Value (Calculator)**	**Impact of Benefit Difference**	**Final Actuarial Value**
Silver 4 indiv	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	69.3%	0.9815	68.0%
Silver HDP 2 Indiv	No Differences		68.9%	1.0000	68.9%
Silver HDP 1 Indiv	No Differences		68.8%	1.0000	68.8%
Silver HDP 1 200-250% 72-74	No Differences		73.2%	1.0000	73.2%
Silver HDP 1 150-200% 86-88	No Differences		87.7%	1.0000	87.7%
Silver HDP 1 100-150% 93-95	No Differences		93.6%	1.0000	93.6%
Gold HDP 1	No Differences		78.8%	1.0000	78.8%
Gold 2	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	79.8%	0.9895	79.0%
Gold 1	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	82.5%	0.9924	81.9%
Catastrophic	No Differences		60.4%	1.0000	60.4%

APPENDIX III
PLAN DESCRIPTIONS

		Gold HDP1	Gold 2	Gold 1	Silver 1	Silver 1 200-250% 72-74	Silver 1 150-200% 86-88	Silver 1 100-150% 93-95	Silver 3	Silver 2	Silver 2 200-250% 72-74	Silver 2 150-200% 86-88
Deductible	Single	$2,000	$1,000	$500	$2,000	$2,000	$250	$75	$2,500	$3,500	$2,750	$450
	Family	$4,000	$2,000	$1,000	$4,000	$4,000	$500	$150	$5,000	$7,000	$5,500	$900
Out of Pocket Maximum	Single	$2,000	$4,000	$4,500	$6,400	$5,200	$2,250	$1,000	$6,400	$6,400	$5,200	$2,250
	Family	$4,000	$8,000	$9,000	$12,800	$10,400	$4,500	$2,000	$12,800	$12,800	$10,400	$4,500
Coinsurance		100%	70%	80%	70%	70%	80%	90%	70%	70%	70%	80%
Office/Free Standing Clinic	PCP	Ded/Coins	$20	$20	$25	$20	$10	$5	$25	$25	$20	$10
	Specialist	Ded/Coins	$50	$50	$50	$45	$25	$10	$50	$50	$50	$30
	Lab	Ded/Coins	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Xray	Ded/Coins	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Hospital	IP	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	OP Surg	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Surgeon	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	100%	100%	Ded/Coins	Ded/Coins	Ded/Coins	100%
	Major DX	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab/X-Ray	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	$50	$25	Ded/Coins	Ded/Coins	Ded/Coins	$50
Emergency Room		Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Urgent Care		Ded/Coins	Ded/Coins	$50	$50	$50	$25	$10	$50	$50	$50	$30
PT/OT/ST		Ded/Coins	Ded/Coins	Coins	$50	$45	$25	$10	$50	$50	$50	$30
All Other		Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Pharmacy	Generic	Ded/Coins	$10	$10	$10	$10	$10	$4	$10	$10	$10	$10
	Preferred Brand	Ded/Coins	$30	$30	$40	$35	$25	$15	$40	$40	$35	$25
	Non-Pref Brand	Ded/Coins	$60	$60	$75	$60	$50	$35	$75	$75	$60	$50
	Specialty	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	$50	$25	Ded/Coins	Ded/Coins	Ded/Coins	$50

		Silver 2 100-150% 93-95	Silver 4	Silver HDP 2 H.S.A	Silver HDP 1 H.S.A	Silver HDP 1 200-250% 72-74	Silver HDP 1 150-200% 86-88	Silver HDP 1 100-150% 93-95	Bronze HDP 2	Bronze HDP 1	Bronze 1	Catastrophic Plan
Deductible	Single	$150	$4,750	$2,000	$3,500	$2,750	$1,000	$250	$5,500	$6,250	$4,000	$6,400
	Family	$300	$9,500	$4,000	$7,000	$5,500	$2,000	$500	$11,000	$12,500	$8,000	$12,800
Out of Pocket Maximum	Single	$1,000	$6,400	$6,000	$3,500	$2,750	$1,000	$500	$5,500	$6,250	$6,400	$6,400
	Family	$2,000	$12,800	$12,000	$7,000	$5,500	$2,000	$1,000	$11,000	$12,500	$12,800	$12,800
Coinsurance		100%	90%	70%	80%	100%	100%	100%	70%	100%	100%	60%
Office/Free Standing Clinic	PCP	$5	$25	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	$30	Ded/Coins
	Specialist	$15	$50	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab	100%	100%	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Xray	100%	100%	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Hospital	IP	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	OP Surg	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Surgeon	100%	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Major DX	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab/X-Ray	$50	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Emergency Room		Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Urgent Care		Ded/Coins	$15	$50	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
PT/OT/ST		Ded/Coins	$15	$50	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
All Other		Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Pharmacy	Generic	$4	$10	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Preferred Brand	$15	$40	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Non-Pref Brand	$35	$75	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Specialty	$50	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins

State: Tennessee **Filing Company:** Community Health Alliance Mutual Insurance Company
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: CHA Individual
Project Name/Number: /

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/13/2013		Form	Individual	06/14/2013	Individual Schedules.pdf (Superceded)
06/13/2013		Supporting Document	Modified Plan and Benefits	06/14/2013	ModifiedPlanandBenefitChart_Individual_OffExchange.xlsx (Superceded)
06/13/2013		Rate	CHA Individual Rates	06/14/2013	CHA Individual_SERFF Format.xls (Superceded)

SERFF Tracking #:	CHAM-129074749	**State Tracking #:**	H-130572	**Company Tracking #:**

State:	Tennessee	**Filing Company:**	Community Health Alliance Mutual Insurance Company
TOI/Sub-TOI:	H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)		
Product Name:	CHA Individual		
Project Name/Number:	/		

Attachment ModifiedPlanandBenefitChart_Individual_OffExchange.xlsx is not a PDF document and cannot be reproduced here.

Attachment CHA Individual_SERFF Format.xls is not a PDF document and cannot be reproduced here.

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$4,000
Family	$8,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,350
Family	$12,700
Coinsurance	40% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$30 Copay
Specialist Office Visit	40% Coinsurance after Deductible
Other Practitioner	40% Coinsurance after Deductible
Prenatal and Postnatal Care	40% Coinsurance after Deductible
Family Planning and Reproductive Services	40% Coinsurance after Deductible
Chiropractic Care	$30 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	40% Coinsurance after Deductible
Office Laboratory	40% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	40% Coinsurance after Deductible
Diabetic Care Management	40% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	40% Coinsurance after Deductible
Dental Anesthesia	40% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	40% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	40% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	40% Coinsurance after Deductible
Hospice Services	40% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	40% Coinsurance after Deductible
Inpatient Physician and Surgical Services	40% Coinsurance after Deductible

Skilled Nursing Facility	40% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	40% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	40% Coinsurance after Deductible
Urgent Care Centers or Facilities	40% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	40% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	40% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	40% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	40% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	40% Coinsurance after Deductible
Reconstructive Surgery	40% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	40% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	40% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	40% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	40% Coinsurance after Deductible
Home Health Care Services	40% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	40% Coinsurance after Deductible
Durable Medical Equipment	40% Coinsurance after Deductible
Hearing Aids	40% Coinsurance after Deductible

Rehabilitative Speech Therapy	40% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	40% Coinsurance after Deductible
Clinical Trials	40% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 40% Coinsurance after Deductible
	Preferred Brand Drugs 40% Coinsurance after Deductible
	Non-Preferred Brand Drugs 40% Coinsurance after Deductible
	Specialty Drugs – 40% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 40% Coinsurance after Deductible
	Preferred Brand Drugs - 40% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 40% Coinsurance after Deductible
	Specialty Drugs – 40% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	40% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	40% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	40% Coinsurance after Deductible
Transplants	40% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$6,250
Family	$12,500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,250
Family	$12,500
Coinsurance	0% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible
Prenatal and Postnatal Care	0% Coinsurance after Deductible
Family Planning and Reproductive Services	0% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible
Office Laboratory	0% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	0% Coinsurance after Deductible
Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	0% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	0% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance after Deductible

Skilled Nursing Facility	0% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	0% Coinsurance after Deductible
Urgent Care Centers or Facilities	0% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	0% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	0% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	0% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	0% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible

Rehabilitative Speech Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	0% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 0% Coinsurance after Deductible
	Preferred Brand Drugs 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible
	Preferred Brand Drugs - 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	0% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	0% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible
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EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$5,500
Family	$11,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$5,500
Family	$11,000
Coinsurance	0% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible
Prenatal and Postnatal Care	0% Coinsurance after Deductible
Family Planning and Reproductive Services	0% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible
Office Laboratory	0% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	0% Coinsurance after Deductible
Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	0% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	0% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible
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Skilled Nursing Facility	0% Coinsurance after Deductible Limit of 60 Days per Benefit Period
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Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	0% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	0% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible

Rehabilitative Speech Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	0% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 0% Coinsurance after Deductible
	Preferred Brand Drugs 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs 0% Coinsurance after Deductible
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	Specialty Drugs – 0% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	0% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	0% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible
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Deductibles	
Individual	$6,350
Family	$12,700
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,350
Family	$12,700
Coinsurance	0% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible
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Diabetic Care Management	0% Coinsurance after Deductible
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Hospice Services	0% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible
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Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	0% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	0% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible

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	Preferred Brand Drugs 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible
	Preferred Brand Drugs - 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	0% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	0% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$500
Family	$1,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$4,500
Family	$9,000
Coinsurance	20% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$20 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$20 Copay
Prenatal and Postnatal Care	$20 Copay
Family Planning and Reproductive Services	20% Coinsurance after Deductible
Chiropractic Care	$20 Copay
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	20% Coinsurance after Deductible
Diabetic Care Management	20% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	20% Coinsurance after Deductible
Dental Anesthesia	20% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible

Skilled Nursing Facility	20% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	20% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	20% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	20% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	20% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Deductible
Reconstructive Surgery	20% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	20% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	20% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	20% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	20% Coinsurance after Deductible
Home Health Care Services	20% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Hearing Aids	20% Coinsurance after Deductible

Rehabilitative Speech Therapy	20% Coinsurance Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% Coinsurance Limit of 20 Visits per Calendar Year
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible
Prosthetic Devices	20% Coinsurance after Deductible
Clinical Trials	20% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $30 Copay
	Non-Preferred Brand Drugs - $60 Copay
	Specialty Drugs – 20% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $90 Copay, Retail; $60 Copay, Mail Order
	Non-Preferred Brand Drugs - $180 Copay, Retail; $120, Mail Order
	Specialty Drugs – 20% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	20% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	20% Coinsurance after Deductible
Transplants	20% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$ 1,000
Family	$2,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$4,000
Family	$8,000
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$20 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$20 Copay
Prenatal and Postnatal Care	$20 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$20 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	30% Coinsurance after Deductible
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	30% Coinsurance Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	30% Coinsurance Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $30 Copay
	Non-Preferred Brand Drugs - $60 Copay
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $90 Copay, Retail; $60 Copay, Mail Order
	Non-Preferred Brand Drugs - $180 Copay, Retail; $120, Mail Order
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$2,000
Family	$4,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$2,000
Family	$4,000
Coinsurance	0% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible
Prenatal and Postnatal Care	0% Coinsurance after Deductible
Family Planning and Reproductive Services	0% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible
Office Laboratory	0% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	0% Coinsurance after Deductible
Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	0% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	0% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance after Deductible

Skilled Nursing Facility	0% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	0% Coinsurance after Deductible
Urgent Care Centers or Facilities	0% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	0% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	0% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	0% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	0% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible

Hearing Aids	0% Coinsurance after Deductible
Rehabilitative Speech Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	0% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 0% Coinsurance after Deductible
	Preferred Brand Drugs 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible
	Preferred Brand Drugs - 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	0% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	0% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$ 2,000
Family	$4,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,350
Family	$12,700
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$25 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$25 Copay
Prenatal and Postnatal Care	$25 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$25 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	0% Coinsurance
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $40 Copay
	Non-Preferred Brand Drugs - $75 Copay
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $120 Copay, Retail; $80 Copay, Mail Order
	Non-Preferred Brand Drugs - $225 Copay, Retail; $150, Mail Order
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$ 2,000
Family	$4,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$5,200
Family	$10,400
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$20 Copay
Specialist Office Visit	$45 Copay
Other Practitioner	$20 Copay
Prenatal and Postnatal Care	$20 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$20 Copay
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	0% Coinsurance
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$45 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	$45 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$45 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $35 Copay
	Non-Preferred Brand Drugs - $60 Copay
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $105 Copay, Retail; $70 Copay, Mail Order
	Non-Preferred Brand Drugs - $180 Copay, Retail; $120, Mail Order
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

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	In-Network
Deductibles	
Individual	$250
Family	$500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$2,250
Family	$4,500
Coinsurance	20% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$10 Copay
Specialist Office Visit	$25 Copay
Other Practitioner	$10 Copay
Prenatal and Postnatal Care	$10 Copay
Family Planning and Reproductive Services	20% Coinsurance after Deductible
Chiropractic Care	$10 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	$0 Copay
Treatment for Temporomandibular Joint Disorders	20% Coinsurance after Deductible
Diabetic Care Management	20% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	20% Coinsurance after Deductible
Dental Anesthesia	20% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$25 Copay
Services Received at a Facility	
Outpatient Facility Fee	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible

Skilled Nursing Facility	20% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	20% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	20% Coinsurance after Deductible
Urgent Care Centers or Facilities	$25 Copay
Delivery and All Inpatient Services for Maternity Care	20% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	20% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Deductible
Reconstructive Surgery	20% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	20% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	$50 Copay
Laboratory Outpatient and Professional Services	$50 Copay
Other Services	
Emergency Transport/Ambulance	20% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	20% Coinsurance after Deductible
Home Health Care Services	20% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible

Hearing Aids	20% Coinsurance after Deductible
Rehabilitative Speech Therapy	$25 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$25 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	20% Coinsurance after Deductible
Clinical Trials	20% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $25 Copay
	Non-Preferred Brand Drugs - $50 Copay
	Specialty Drugs – 20% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $75 Copay, Retail; $50 Copay, Mail Order
	Non-Preferred Brand Drugs - $150 Copay, Retail; $100, Mail Order
	Specialty Drugs – 20% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	20% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	20% Coinsurance after Deductible
Transplants	20% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$75
Family	$150
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$1,000
Family	$2,000
Coinsurance	10% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$5 Copay
Specialist Office Visit	$10 Copay
Other Practitioner	$5 Copay
Prenatal and Postnatal Care	$5 Copay
Family Planning and Reproductive Services	10% Coinsurance after Deductible
Chiropractic Care	$5 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	10% Coinsurance after Deductible
Diabetic Care Management	10% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	10% Coinsurance after Deductible
Dental Anesthesia	10% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$10 Copay
Services Received at a Facility	
Outpatient Facility Fee	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance
Hospice Services	10% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance

Skilled Nursing Facility	10% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	10% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	10% Coinsurance after Deductible
Urgent Care Centers or Facilities	$10 Copay
Delivery and All Inpatient Services for Maternity Care	10% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	10% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	10% Coinsurance after Deductible
Reconstructive Surgery	10% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	10% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	$25 Copay
Laboratory Outpatient and Professional Services	$25 Copay
Other Services	
Emergency Transport/Ambulance	10% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	10% Coinsurance after Deductible
Home Health Care Services	10% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Hearing Aids	10% Coinsurance after Deductible

Rehabilitative Speech Therapy	$10 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$10 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	10% Coinsurance after Deductible
Clinical Trials	10% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $4 Copay
	Preferred Brand Drugs - $15 Copay
	Non-Preferred Brand Drugs - $35 Copay
	Specialty Drugs – 10% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $12 Copay, Retail; $8 Copay, Mail Order
	Preferred Brand Drugs - $45 Copay, Retail; $30 Copay, Mail Order
	Non-Preferred Brand Drugs - $105 Copay, Retail; $70, Mail Order
	Specialty Drugs – 10% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	10% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	10% Coinsurance after Deductible
Transplants	10% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$3,500
Family	$7,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,350
Family	$12,700
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$25 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$25 Copay
Prenatal and Postnatal Care	$25 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$25 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	0% Coinsurance
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $40 Copay
	Non-Preferred Brand Drugs - $75 Copay
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $120 Copay, Retail; $80 Copay, Mail Order
	Non-Preferred Brand Drugs - $225 Copay, Retail; $150, Mail Order
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

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	In-Network
Deductibles	
Individual	$2,750
Family	$5,500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$5,200
Family	$10,400
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$20 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$20 Copay
Prenatal and Postnatal Care	$20 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$20 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	30% Coinsurance after Deductible
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $35 Copay
	Non-Preferred Brand Drugs - $60 Copay
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $105 Copay, Retail; $70 Copay, Mail Order
	Non-Preferred Brand Drugs - $180 Copay, Retail; $120, Mail Order
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
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	In-Network
Deductibles	
Individual	$450
Family	$900
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$2,250
Family	$4,500
Coinsurance	20% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$10 Copay
Specialist Office Visit	$30 Copay
Other Practitioner	$10 Copay
Prenatal and Postnatal Care	$10 Copay
Family Planning and Reproductive Services	20% Coinsurance after Deductible
Chiropractic Care	$10 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	20% Coinsurance after Deductible
Diabetic Care Management	20% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	20% Coinsurance after Deductible
Dental Anesthesia	20% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$30 Copay
Services Received at a Facility	
Outpatient Facility Fee	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible

Skilled Nursing Facility	20% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	20% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	20% Coinsurance after Deductible
Urgent Care Centers or Facilities	$30 Copay
Delivery and All Inpatient Services for Maternity Care	20% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	20% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Deductible
Reconstructive Surgery	20% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	20% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	$50 Copay
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	20% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	20% Coinsurance after Deductible
Home Health Care Services	20% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Hearing Aids	20% Coinsurance after Deductible

Rehabilitative Speech Therapy	$30 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$30 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	20% Coinsurance after Deductible
Clinical Trials	20% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $25 Copay
	Non-Preferred Brand Drugs - $50 Copay
	Specialty Drugs – 20% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $75 Copay, Retail; $50 Copay, Mail Order
	Non-Preferred Brand Drugs - $150 Copay, Retail; $100, Mail Order
	Specialty Drugs – 20% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	20% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	20% Coinsurance after Deductible
Transplants	20% Coinsurance after Deductible
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	In-Network
Deductibles	
Individual	$150
Family	$300
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$1,000
Family	$2,000
Coinsurance	10% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$5 Copay
Specialist Office Visit	$15 Copay
Other Practitioner	$5 Copay
Prenatal and Postnatal Care	$5 Copay
Family Planning and Reproductive Services	10% Coinsurance after Deductible
Chiropractic Care	$5 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	10% Coinsurance after Deductible
Diabetic Care Management	10% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	10% Coinsurance after Deductible
Dental Anesthesia	10% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$15 Copay
Services Received at a Facility	
Outpatient Facility Fee	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible

Skilled Nursing Facility	10% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	10% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	10% Coinsurance after Deductible
Urgent Care Centers or Facilities	$15 Copay
Delivery and All Inpatient Services for Maternity Care	10% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	10% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	10% Coinsurance after Deductible
Reconstructive Surgery	10% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	10% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	$50 Copay
Laboratory Outpatient and Professional Services	0% Coinsurance
Other Services	
Emergency Transport/Ambulance	10% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	10% Coinsurance after Deductible
Home Health Care Services	10% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Hearing Aids	10% Coinsurance after Deductible

Rehabilitative Speech Therapy	$15 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$15 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	10% Coinsurance after Deductible
Clinical Trials	10% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $4 Copay
	Preferred Brand Drugs - $15 Copay
	Non-Preferred Brand Drugs - $35 Copay
	Specialty Drugs – 10% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $12 Copay, Retail; $8 Copay, Mail Order
	Preferred Brand Drugs - $45 Copay, Retail; $30 Copay, Mail Order
	Non-Preferred Brand Drugs - $105 Copay, Retail; $70, Mail Order
	Specialty Drugs – 10% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	10% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	10% Coinsurance after Deductible
Transplants	10% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$2,500
Family	$5,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,350
Family	$12,700
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$25 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$25 Copay
Prenatal and Postnatal Care	$25 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$25 Copay Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	30% Coinsurance after Deductible
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $40 Copay
	Non-Preferred Brand Drugs - $75 Copay
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $120 Copay, Retail; $80 Copay, Mail Order
	Non-Preferred Brand Drugs - $225 Copay, Retail; $150, Mail Order
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$4,750
Family	$9,500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,350
Family	$12,700
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$25 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$25 Copay
Prenatal and Postnatal Care	$25 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$25 Copay
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	30% Coinsurance after Deductible
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $40 Copay
	Non-Preferred Brand Drugs - $75 Copay
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $120 Copay, Retail; $80 Copay, Mail Order
	Non-Preferred Brand Drugs - $225 Copay, Retail; $150, Mail Order
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$3,500
Family	$7,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$3,500
Family	$7,000
Coinsurance	0% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible
Prenatal and Postnatal Care	0% Coinsurance after Deductible
Family Planning and Reproductive Services	0% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible
Office Laboratory	0% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	0% Coinsurance after Deductible
Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	0% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	0% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance after Deductible

Skilled Nursing Facility	0% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	0% Coinsurance after Deductible
Urgent Care Centers or Facilities	0% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	0% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	0% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	0% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	0% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible

Rehabilitative Speech Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	0% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 0% Coinsurance after Deductible
	Preferred Brand Drugs 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible
	Preferred Brand Drugs - 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	0% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	0% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$2,750
Family	$5,500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$2,750
Family	$5,500
Coinsurance	0% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible
Prenatal and Postnatal Care	0% Coinsurance after Deductible
Family Planning and Reproductive Services	0% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible
Office Laboratory	0% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	0% Coinsurance after Deductible
Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	0% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	0% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance after Deductible

Skilled Nursing Facility	0% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	0% Coinsurance after Deductible
Urgent Care Centers or Facilities	0% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	0% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	0% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	0% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	0% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible

Rehabilitative Speech Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	0% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 0% Coinsurance after Deductible
	Preferred Brand Drugs 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible
	Preferred Brand Drugs - 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	0% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	0% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$1,000
Family	$2,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$1,000
Family	$2,000
Coinsurance	0% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	0% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible
Prenatal and Postnatal Care	0% Coinsurance after Deductible
Family Planning and Reproductive Services	0% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible
Office Laboratory	0% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	0% Coinsurance after Deductible
Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	0% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	0% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance after Deductible

Skilled Nursing Facility	0% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	0% Coinsurance after Deductible
Urgent Care Centers or Facilities	0% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	0% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	0% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	0% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	0% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible

Rehabilitative Speech Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	0% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 0% Coinsurance after Deductible
	Preferred Brand Drugs 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible
	Preferred Brand Drugs - 0% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible
	Specialty Drugs – 0% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	0% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	0% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible
	Pre-certification required

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	In-Network
Deductibles	
Individual	$250
Family	$500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$500
Family	$1,000
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	30% Coinsurance after Deductible
Specialist Office Visit	30% Coinsurance after Deductible
Other Practitioner	30% Coinsurance after Deductible
Prenatal and Postnatal Care	30% Coinsurance after Deductible
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	30% Coinsurance after Deductible
Office Laboratory	30% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	30% Coinsurance after Deductible
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	30% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	30% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	30% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic 30% Coinsurance after Deductible
	Preferred Brand Drugs 30% Coinsurance after Deductible
	Non-Preferred Brand Drugs 30% Coinsurance after Deductible
	Specialty Drugs – 30% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 30% Coinsurance after Deductible
	Preferred Brand Drugs - 30% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 30% Coinsurance after Deductible
	Specialty Drugs – 30% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	30% Coinsurance after Deductible for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$2,000
Family	$4,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$6,000
Family	$12,000
Coinsurance	20% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
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Hearing Aids	20% Coinsurance after Deductible

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	Pre-certification required